

CLOSE TO HOME: HOW OPIOIDS ARE IMPACTING COMMUNITIES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON EARLY CHILDHOOD,
ELEMENTARY, AND SECONDARY EDUCATION

AND THE

SUBCOMMITTEE ON HIGHER EDUCATION AND
WORKFORCE DEVELOPMENT

OF THE

COMMITTEE ON EDUCATION

AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, NOVEMBER 8, 2017

Serial No. 115-28

Printed for the use of the Committee on Education and the Workforce



Available via the World Wide Web: [www.gpo.gov/fdsys/browse/
committee.action?chamber=house&committee=education](http://www.gpo.gov/fdsys/browse/committee.action?chamber=house&committee=education)

or

Committee address: <http://edworkforce.house.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

27-367 PDF

WASHINGTON : 2018

COMMITTEE ON EDUCATION AND THE WORKFORCE

VIRGINIA FOXX, North Carolina, *Chairwoman*

Joe Wilson, South Carolina
Duncan Hunter, California
David P. Roe, Tennessee
Glenn “GT” Thompson, Pennsylvania
Tim Walberg, Michigan
Brett Guthrie, Kentucky
Todd Rokita, Indiana
Lou Barletta, Pennsylvania
Luke Messer, Indiana
Bradley Byrne, Alabama
David Brat, Virginia
Glenn Grothman, Wisconsin
Steve Russell, Oklahoma
Elise Stefanik, New York
Rick W. Allen, Georgia
Jason Lewis, Minnesota
Francis Rooney, Florida
Paul Mitchell, Michigan
Tom Garrett, Jr., Virginia
Lloyd K. Smucker, Pennsylvania
A. Drew Ferguson, IV, Georgia
Ron Estes, Kansas
Karen Handel, Georgia

Robert C. “Bobby” Scott, Virginia
Ranking Member
Susan A. Davis, California
Raúl M. Grijalva, Arizona
Joe Courtney, Connecticut
Marcia L. Fudge, Ohio
Jared Polis, Colorado
Gregorio Kilili Camacho Sablan,
Northern Mariana Islands
Frederica S. Wilson, Florida
Suzanne Bonamici, Oregon
Mark Takano, California
Alma S. Adams, North Carolina
Mark DeSaulnier, California
Donald Norcross, New Jersey
Lisa Blunt Rochester, Delaware
Raja Krishnamoorthi, Illinois
Carol Shea-Porter, New Hampshire
Adriano Espaillat, New York

Brandon Renz, *Staff Director*
Denise Forte, *Minority Staff Director*

SUBCOMMITTEE ON EARLY CHILDHOOD, ELEMENTARY, AND SECONDARY EDUCATION

TODD ROKITA, Indiana, *Chairman*

Duncan Hunter, California
David P. Roe, Tennessee
Glenn “GT” Thompson, Pennsylvania
Luke Messer, Indiana
David Brat, Virginia
Tom Garrett, Jr., Virginia
Karen Handel, Georgia

Jared Polis, Colorado
Ranking Member
Raúl M. Grijalva, Arizona
Marcia L. Fudge, Ohio
Suzanne Bonamici, Oregon
Susan A. Davis, California
Frederica S. Wilson, Florida

SUBCOMMITTEE ON HIGHER EDUCATION AND WORKFORCE
DEVELOPMENT

BRETT GUTHRIE, Kentucky, *Chairman*

Glenn “GT” Thompson, Pennsylvania
Lou Barletta, Pennsylvania
Luke Messer, Indiana
Bradley Byrne, Alabama
Glenn Grothman, Wisconsin
Elise Stefanik, New York
Rick W. Allen, Georgia
Jason Lewis, Minnesota
Paul Mitchell, Michigan
Tom Garrett, Jr., Virginia
Lloyd K. Smucker, Pennsylvania
Ron Estes, Kansas

Susan A. Davis, California
Ranking Member
Joe Courtney, Connecticut
Alma S. Adams, North Carolina
Mark DeSaulnier, California
Raja Krishnamoorthi, Illinois
Jared Polis, Colorado
Gregorio Kilili Camacho Sablan,
Northern Mariana Islands
Mark Takano, California
Lisa Blunt Rochester, Delaware
Adriano Espaillat, New York

C O N T E N T S

Hearing held on November 8, 2017	Page 1
Statement of Members:	
Davis, Hon. Susan, A., Ranking Member, Subcommittee on Higher Education and Workforce Development	8
Prepared statement of	9
Guthrie, Hon. Brett, Chairman, Subcommittee on Higher Education and Workforce Development	6
Prepared statement of	7
Polis, Hon. Jared, Ranking Member, Subcommittee on Early Childhood, Elementary, and Secondary Education	3
Prepared statement of	5
Rokita, Hon. Todd, Chairman, Subcommittee on Early Childhood, Elementary, and Secondary Education	1
Prepared statement of	3
Statement of Witnesses:	
Cox, Dr. David, Partner, Superintendent, Allegany County	41
Prepared statement of	43
Miner, Ms. Toni, Family Support Partner	18
Prepared statement of	20
Robinson, Mr. Tim, Founder and CEO, Addiction Recovery Care	11
Prepared statement of	14
Wen, Dr. Leana, Commissioner, Baltimore City Health Department	27
Prepared statement of	29
Additional Submissions:	
Adams, Hon. Alma, a Representative in Congress from the State of North Carolina:	
Article: President Trumps Says He Wants to Stop the Opioid Crisis, His Actions Don't Match	77
Courtney, Hon. Joe, a Representative in Congress from the State of Connecticut:	
Graph	80
Ms. Davis:	
Article: Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis	82
Mr. Polis:	
Article: Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010	90
Letter dated May 2, 2017, The American Health Care Act Vote	97
Questions submitted for the record by Fudge, Hon Marcia a Representative in Congress from the State of Ohio	102
Dr. Wen's responses to questions submitted for the record	104

CLOSE TO HOME: HOW OPIOIDS ARE IMPACTING COMMUNITIES

Wednesday, November 8, 2017

House of Representatives

**Committee on Education and the Workforce,
Subcommittee on Early Childhood, Elementary,
and Secondary Education**

joint with

**Subcommittee on Higher Education and Workforce Development
Washington, D.C.**

The subcommittees met, pursuant to call, at 10:30 a.m., in Room 2175, Rayburn House Office Building, Hon. Todd Rokita [chairman of the subcommittee on Early Childhood, Elementary, and Secondary Education] presiding.

Present: Representatives Rokita, Guthrie, Barletta, Messer, Byrne, Brat, Grothman, Stefanik, Allen, Lewis, Mitchell, Smucker, Handel, Polis, Davis, Courtney, Fudge, Bonamici, Adams, DeSaulnier, Blunt Rochester, Krishnamoorthi, and Espaillat.

Also Present: Representatives Foxx, Scott, and Shea-Porter.

Staff Present: Courtney Butcher, Director of Member Services and Coalitions; Michael Comer, Press Secretary; Kathlyn Ehl, Professional Staff Member; Rob Green, Director of Workforce Policy; Amy Raaf Jones, Director of Education and Human Resources Policy; Jonas Linde, Professional Staff Member; Nancy Locke, Chief Clerk; Kelley McNabb, Communications Director; Jake Middlebrooks, Legislative Assistant; James Mullen, Director of Information Technology; Krisann Pearce, General Counsel; James Redstone, Professional Staff Member; Mandy Schaumburg, Education Deputy Director and Senior Counsel; Michael Woeste, Press Secretary; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Jacque Chevalier, Minority Director of Education Policy; Mishawn Freeman, Minority Staff Assistant; Carolyn Hughes, Minority Director Health Policy/Senior Labor Policy Advisor; Stephanie Lalle, Minority Digital Press Secretary; Richard Miller, Minority Labor Policy Director; Udochi Onwubiko, Minority Labor Policy Counsel; and Veronique Pluviose, Minority Staff Director.

Chairman ROKITA. A quorum being present the Subcommittee on Early Childhood, Elementary, and Secondary Education and the Subcommittee on Higher Education and Workforce Development will come to order.

Today we will have opening statements from the chairman and the ranking members of our two subcommittees. And, with that, I recognize myself for an opening statement.

Good morning and welcome to today's joint subcommittee hearing with our colleagues from the Subcommittee on Higher Education and Workforce Development. I would like to thank our panel of witnesses and our members today for joining on this important discussion on opioid abuse and addiction that is taking a toll on the Nation as we see every night on our television sets, if not from other places.

The opioid crisis is having a profound impact on families, jobs, communities, and the economy, and that is why we are here today. The issue of drug overdoses due to opioids is only getting worse as death related opioids have quadrupled since 1999. And we have some fast facts up on the screen detailing all of this. In fact, in 2016 alone there were approximately 64,000 fatal drug overdoses. This means that the opioid crisis is claiming the lives of 175 Americans per day. These figures are horrifying and sad, not only for the country's future, but for communities who are losing parents, husbands, wives, teachers, and, yes, students.

Additionally, the opioid epidemic knows no age, gender, educational, credential, or class distinction. This crisis is touching all of us. Some of the most unfortunate stories have to do with children whose lives have been forever changed by this public health emergency. Between 2000 and 2014 the number of babies born drug-dependent increased by 500 percent. In my home State of Indiana a recent pilot program from the State Department of Health found that about one in five infants assessed at hospitals around the State tested positive for opioids, 20 percent of our babies in Indiana.

More and more children are being placed into foster care or are cared for by another relative due to parental drug abuse. According to a recent analysis nearly a third of the children who entered foster care in the U.S. in 2015 alone did so at least partially because of parental drug abuse.

It is one thing to read the statistics and accounts in the news about communities in the midst of an opioid crisis, but these accounts do not compare to the real voices we need to hear from in order to understand this crisis.

I had the opportunity to host a school safety summit last week in my district. One of the two significant topics was the opioid crisis. I heard from Dustin Noonkester, one of the founders of Brady's Hope. Dustin lost his son to opioid overdose. This organization is a resource to members of the community on how to spot abuse, how to address opioid misuse, and how families can help one another treat opioid addiction. Brady was a good student, he was off to a military career and he had 2 weeks to go before boot camp when his life was claimed by this. And it happened over the course of one summer. Started meeting with kids that he hadn't before, and one thing led to another and he was 2 weeks short of getting to boot camp where his life would have been saved.

The epidemic can no longer be ignored and it is important that we hear from those who are on the ground and facing tragic truths of this opioid crisis every day. The witnesses we have gathered

here today understand the opioid problem better than any of us here in Washington perhaps because they see it and they fight it in their communities nearly every hour of every day. So I am pleased this committee can come together to understand this true public health emergency and its impact on communities across the United States.

And with that, it is now my pleasure to yield to the ranking member of the Subcommittee on Early Childhood, Elementary, and Secondary Education, and my friend, Congressman Polis for his opening remarks.

[The information follows:]

Prepared Statement of Hon. Todd Rokita, Chairman, Subcommittee on Early Childhood, Elementary, and Secondary Education

Good morning, and welcome to today's joint subcommittee hearing with our colleagues from the Subcommittee on Higher Education and Workforce Development. I'd like to thank our panel of witnesses and our members for joining today's important discussion on opioid abuse and addiction that is taking a toll on the nation.

The opioid crisis is having a profound impact on families, jobs, communities, and the economy, and that is why we're here today.

The issue of drug overdoses due to opioids is only getting worse as deaths related to opioids have quadrupled since 1999. In 2016 alone, there were approximately 64,000 drug overdoses. This means that the opioid crisis is claiming the lives of 175 Americans per day.

These figures are horrifying and sad not only for the country's future, but for communities who are losing parents, husbands, wives, teachers, and students.

Additionally, the opioid epidemic knows no age, gender, educational credential, or class distinction. This crisis is touching all Americans.

Some of the most unfortunate stories have to do with the children whose lives have been forever changed by this public health emergency.

Between 2000 and 2014, the number of babies born drug-dependent increased by 500 percent. In my home state of Indiana, a recent pilot program from the state Department of Health found that about 1 in 5 infants assessed at hospitals around the state tested positive for opiates.

More and more children are being placed into foster care or are cared for by another relative due to parental drug abuse. According to a recent analysis, nearly a third of the children who entered foster care in the U.S. in 2015 did so at least partially because of parental drug abuse.

It is one thing to read the statistics and accounts in the news about communities in the midst of the opioid crisis, but these accounts do not compare to the real voices we need to hear from in order to understand this crisis.

I had the opportunity to host a school safety summit last week in my district. One of the two big topics was the opioid crisis. I heard from Dustin Noonkester, one of the founders of "Brady's Hope." Dustin lost his son to opioid overdose. This organization is a resource to members of the community on how to spot abuse, how to address opioid misuse, and how families can help one another treat opioid addiction.

These are the stories that give me hope that this crisis can be overcome.

This epidemic can no longer be ignored, and it is important that we hear from those who are on the ground and facing the tragic truths of the opioid crisis every day.

The witnesses we have gathered here today understand the opioid problem better than any of us here in Washington, because they see it, and fight it, in their communities.

I am pleased this committee can come together to understand this true public health emergency and its impact on communities across the United States.

Mr. POLIS. Thank you, Chairman Rokita, for holding this very important hearing. As we know, the opioid crisis cuts across State lines, across party lines, it affects each of us in our congressional districts, and many of us in our neighborhoods and families. In my home State of Colorado the rate of drug overdose deaths since 2000 has more than doubled. The impact of the opioid crisis needs to en-

gender a strong bipartisan response from Congress, and I am thankful that we are beginning to have an important discussion through our joint subcommittee this morning.

Addressing the opioid crisis should be a top priority for the United States Congress, for our States, for our local governments. Last year Congress passed, and President Obama signed, a law with a new set of policies that helped restructure our prevention and treatment efforts to better respond to substance abuse problems. Unfortunately, it did not provide the funding necessary to effect change and this crisis. We need to match our rhetoric with action and with real resources. That means understanding the role that many programs fill in crafting a holistic approach to the crisis, programs within the jurisdiction of this committee and programs within the jurisdiction of other committees. For example, early learning programs, helping care for children who experienced a trauma of having addicted parents.

Public schools are on the front line in the delivery and coordination of services for students impacted by addiction. Congress should fully fund programs authorized under ESSA to ensure that teachers and school leaders are equipped to be ready and willing partners in addressing the opioid addiction and opioid use disorder.

We can't overstate the importance of access to health coverage in this discussion. Medicaid and the Affordable Care Act have been improved and expanded to provide healthcare coverage to many who lacked it. In my home State alone 400,000 Coloradans have access to health insurance through the Medicaid expansion alone.

Finally, as we address the opioid addiction crisis we have to remember that many communities were suffering from substance abuse disorders long before this current crisis. While the level and number of deaths has increased, addiction has always been a problem in our communities, in both rural communities, in urban and suburban communities, in every congressional district.

We need to think critically about alternative options to addressing this crisis. For some communities, such as veterans, as we see in Colorado, cannabis should be considered as a replacement therapy for chronic pain management. Research suggests that implementing medical cannabis programs can reduce pain management medications associated with mortality, like opioid prescription drugs. It also can improve pain management and significantly reduce healthcare costs. In fact, a recent Journal of American Medical Association study analyzed all 50 States and found that those with medical marijuana laws had 25 percent fewer fatal opioid overdoses than States that did not have those laws between 1999 and 2010.

At this time I ask unanimous consent to place this study in the record.

Chairman ROKITA. Without objection.

Mr. POLIS. Recently I was honored to present a Purple Heart to a veteran who lives in my district. This 29-year-old man put his life on the line for our country and he told me he uses medical marijuana for all of his pain management and sleep issues and he has been able to successfully take himself off of the prescription opioids that the VA prescribed. His girlfriend also bore witness to the fact

that he is much better for it. And these are the kinds of stories and data that we need to look at in addressing the opioid crisis.

It is encouraging that Congress is taking this time to discuss the issue, and it is important that this committee is staying involved in the Federal response to the opioid epidemic. I know that members on both sides of the aisle will have thoughtful questions and ideas both to address the under resourcing of programs and to make sure that we can address this issue in a comprehensive manner.

I want to thank our panelists for taking the time to testify today. I look forward to hearing from everybody.

And I yield back the balance of my time.

[The information follows:]

Prepared Statement of Hon. Jared Polis, Ranking Member, Subcommittee on Early Childhood, Elementary, and Secondary Education

Thank you, Chairman Rokita, for holding this important hearing today.

As each of us here knows, the opioid crisis is one that cuts across state lines and affects each of our congressional districts. In Colorado, the rate of drug overdose deaths since 2000 has more than doubled. The impact of the opioid crisis isn't a partisan issue, and our response shouldn't be either. I'm thankful we're able to discuss this important issue at our joint subcommittee hearing this morning.

Addressing the opioid crisis should be a top priority for Congress. Last year, Congress passed and President Obama signed into law a set of policies that helped restructure our prevention and treatment efforts to better respond to substance use disorder. It did not, however, provide the funding necessary to affect the change needed to address this crisis.

To truly respond to this epidemic, we have to walk the walk, and without funding, we will not be doing enough for our constituents to move the needle.

We must match our rhetoric with action and real money. That means understanding the role that many programs fill in crafting a holistic approach to this crisis – programs within the jurisdiction of this Committee. For example, early learning programs help care for children who experience the trauma of having addicted parents. Public schools are on the front line in the delivery and coordination of services for students impacted by addiction. Congress must fully fund programs authorized under ESSA to ensure that teachers and school leaders are equipped to be ready partners in addressing opioid addiction and opioid use disorder.

We also cannot overstate the importance of access to health coverage in this discussion. Medicaid and the Affordable Care Act have dramatically improved and expanded access to health coverage, a vital part of responding to opioid use disorder and ensuring that Americans can get both needed preventive care and treatment. In my state alone, over 400,000 Coloradans have access to health insurance now through the Medicaid expansion.

But for the last ten months and counting, we have wasted precious time trying to repeal the Affordable Care Act and Medicaid expansion. This is especially cruel because 1.6 million people with substance abuse disorders now have access to treatment precisely because 31 states expanded Medicaid as part of the ACA.

Even last week, House Republicans advanced a bill that would cut billions from the Affordable Care Act's Public Health and Prevention Fund, which helps states prevent and respond to the opioid epidemic.

Finally, as we address the opioid addiction, we have to remember that many communities were suffering from substance use disorders long before Congress woke up to this issue. Addiction affects both rural and urban communities and every Congressional district. Efforts to address addiction through treatment, instead of incarceration and instead of punishment, should apply to all communities as well.

We also need to think critically about alternative options to addressing this crisis. For some communities, such as veterans, cannabis should be considered as a replacement therapy for chronic pain treatment. Early research suggests implementing medical cannabis programs could reduce pain management medications associated mortality, improve pain management, and significantly reduce health care costs. In fact, a recent Journal of American Medical Association study analyzed all 50 states and found that those with medical marijuana laws had 25% fewer fatal opioid overdoses than states that had no such laws between 1999 and 2010.

At this time, I ask unanimous consent to place this study into the record.

Recently, I was honored to present a Purple Heart to a veteran who lives in Boulder, Colorado. This 29 year old young man put his life on the line for our country. He told me that he uses medical marijuana for all his pain and sleep issues, and has been able to take himself off all opioids the VA had prescribed. His girlfriend testified to the fact that he's so much better for it. These are the type of stories we need to listen to.

It's encouraging that Congress is taking time to discuss this issue and it is important that this Committee stay very involved in the federal response to the opioid epidemic. I am hopeful that we can address it through increased funding for effective, under-resourced programs and locally-driven state and federal initiatives that are built on evidence-based practices, not stigma or misperceptions about proven treatment strategies.

I thank the panelists for taking the time to testify today. I look forward to hearing from you.

Thank you, and I yield back the balance of my time.

Chairman ROKITA. I thank the gentleman. I will now yield to the chairman of the Subcommittee on Higher Education and the Workforce for his opening remarks.

Chairman GUTHRIE. Thank you, Chairman Rokita. I want to echo the chairman's appreciation for the witnesses here today.

The opioid crisis is having a profound impact on my constituents as well. And I am sure the stories we hear from the witnesses today resonate with many of the stories I have heard in Kentucky. The opioid crisis is a public health emergency and Congress must continue working to face the epidemic that has had an impact on all aspects of our society. Unfortunately, a problem as widespread as the opioid epidemic, which has already had an impact of 11.5 million Americans has also taken a devastating toll on local economies and the national economy as a whole, and we are only beginning to see more clearly. As the opioid health emergency continues to worsen, the economy will continue to suffer. Data from CDC analyzing opioid overdose deaths by age groups in 1999 and 2015 show that people most likely to die of an opioid overdose are between the ages of 25 and 39 years old. These are people who have entire lives, careers, and untold contributions to make to their communities and our country ahead of them. Numbers are important, but people with their own stories are at the heart of this crisis.

To Americans who live in some of the areas hardest hit by the opioid crisis, including my home State of Kentucky, they are seeing their coworkers, bosses, friends, and family members suffer from this horrible affliction. The administration and Congress are coming together to identify community-based solutions to combat this crisis. But the day-to-day hard work fighting this outbreak is already being done on the ground by the people that face this issue every day. The witnesses we have gathered here today have seen the impact the opioid crisis is having on their communities every day and it is important we hear the stories of how it specifically impacted them as individuals, as well as their friends, families, and coworkers.

When it comes to finding solutions for the workforce development needs and creating more good paying jobs, we look to State and local entities who are leading by example and the opioid crisis is no different. Our witnesses before us have learned a lot in their communities about how to spot opioid abuse and implement successful forms of treatment. It is important we hear about these ex-

periences in order to inform the congressional response to this crisis.

At this committee we talk a lot about how we are addressing the shortage of skilled workers across the country and how we want to empower people to build the lives they want for themselves. For many workers ensnared in this epidemic, it is critical that they receive the treatment they need to help them return to the workforce and to find a good job once they are drug free. We also have to acknowledge that the opioid crisis resulting in too many lives ending far too soon and we have to look at ways to stop it.

I would like to welcome Tim Robinson here today from my home State of Kentucky. I know that Tim and I were discussing earlier Louisa, where he is from, is probably closer to this capital building than it is to my hometown of Bowling Green, but it just shows how broad and wide and diverse Kentucky is and the problem is pervasive through all economic groups, all people, and it is something that we are struggling with. I know that the dean of the Kentucky delegation, Hal Rogers, has been a strong supporter of what you do in Louisa and Martin County and all through Appalachia, and also across the Commonwealth.

So I certainly appreciate you being here today and your testimony in a few minutes. I appreciate the witnesses for appearing and I look forward to hearing your testimony.

And I yield back.

[The information follows:]

Prepared Statement of Hon. Brett Guthrie, Chairman, Subcommittee on Higher Education and Workforce Development

Thank you Subcommittee Chairman Rokita, and I want to echo the Chairman's appreciation for the witnesses joining us at today's hearing. The opioid crisis is having a profound impact on my constituents as well, and I'm sure the stories we will hear from the witnesses today will resonate with many of the stories I have heard in Kentucky.

The opioid crisis is a public health emergency and Congress must continue working to face the epidemic that has had an impact on all aspects of our society.

Unfortunately, a problem as widespread as the opioid epidemic, which has already had an impact on over 11.5 million Americans, also has taken a devastating toll on local economies and the national economy as a whole, as we're only beginning to see more clearly.

As the opioid public health emergency continues to worsen, the economy will continue to suffer.

Data from the CDC analyzing opioid overdose deaths by age groups in 1999 and 2015 showed that the people most likely to die of an opioid overdose are between the ages of 25 and 39 years old.

These are people who had entire lives, careers, and untold contributions to make to their communities and our country ahead of them.

Numbers are important, but people with their own stories are at the heart of this crisis.

To Americans who live in some of the areas hardest hit by the opioid crisis, including my home state of Kentucky, they are seeing their coworkers, bosses, friends, and family members suffer from this horrible affliction.

The administration and Congress are coming together to identify community-based solutions to combat this crisis, but the day-to-day hard work fighting this outbreak is already being done on the ground by the people that face this issue every day.

The witnesses we have gathered here today have seen the impact the opioid crisis is having on their communities every day, and it's important we hear their stories of how it has specifically impacted them as individuals, as well as their friends, families, and coworkers.

When it comes to finding solutions for workforce development needs, and creating more good-paying jobs, we look to state and local entities who are leading by example, and the opioid crisis is no different.

Our witnesses before us have learned a lot in their communities about how to spot opioid abuse and implement successful forms of treatment. It is important we hear about these experiences in order to inform the Congressional response to the crisis.

At this Committee, we talk a lot about how we are addressing the shortage of skilled workers across the country, and how we want to empower people to build the lives they want for themselves. For many workers ensnared in this epidemic, it is critical that they receive the treatment they need to help them return to the workforce, and find a good job once they are drug-free. We also have to acknowledge that the opioid crisis is resulting in too many lives ending far too soon, and we have to look at ways to stop it.

I'd like to welcome Tim Robinson from my home state of Kentucky who is testifying here today. Tim is the founder and CEO of Addiction Recovery Care in Louisa, Kentucky, which is a network of 13 addiction treatment centers. Thank you for the work you are doing to serve your community and the Commonwealth. I look forward to hearing your testimony today.

I appreciate the witnesses for appearing before this committee, and look forward to hearing how they have responded in their own communities to combat this crisis.

Chairman ROKITA. Thank you, Chairman Guthrie, and I yield to the ranking member of the Subcommittee on Higher Education & the Workforce, Congresswoman Davis, for her opening remarks.

Ms. DAVIS. Thank you. Thank you, Mr. Chair. As my colleagues have said, and I want to point how much in sync I think that we are on many of these issues, the opioid crisis has greatly impacted our communities. In 2015, more than 33,000 Americans died of an opioid overdose and more than 2 million individuals had an opioid use disorder.

In California, more people die from drug overdose each year than from auto accidents. And that is why it is so important to continue to invest in the Federal programs that promote addiction recovery and treatment. Across the country and in California Medicaid has been vital to addressing the opioid epidemic. Adults with Medicaid coverage are about three times more likely to have received treatment as inpatients and almost twice as likely to have received outpatient treatment than privately insured adults. As Ranking Member Polis has noted, in our efforts to combat this epidemic it is vital that we invest in the systems, systems and the programs that support healthy families in communities, and this means a strong workforce. And I am pleased that my colleague has also echoed that interest.

As we have seen with past drug epidemics that have rocked our communities the opioid epidemic has a strong link to jobs. According to recent research an estimated 25 percent of the drop in women's workforce participation between '99 and 2015 can be attributed to the increase in opioid prescriptions, and for men that number is about 20 percent. And we know that when adults, particularly women, are not working it has significant impacts on the economic security of their families and communities.

For example, job loss for a parent can mean lower wages and unemployment for their children later in life. It is particularly important to note the relationship between opioid abuse and unemployment. This means that individuals may fall out of the job force due to their dependence on opioids or it may be that they become addicted after job loss. We must help people remain employed and breakdown the barriers for individuals struggling with opioid abuse

problems as they seek to reenter the workforce. And this means rethinking employer drug testing policies and using a more thoughtful approach for those in the criminal justice system. We must also leverage our workforce development systems to ensure that our workers, especially those in communities impacted by trade and technology, have access to the skills development that they need. Integrating job training into treatment efforts is also key. Linking these services can be crucial for helping people reenter the workforce and improve the probability of long-term recovery efforts.

Now, we know that the Trump administration has declared a nationwide public health emergency to address the opioid crisis. And as part of this declaration the administration has directed the Department of Labor to use dislocated worker grants to, "Help workers who have been displaced from the workforce because of the opioid crisis subject to available funding." Unfortunately, we will not be hearing from anyone from the administration today to get a better understanding of their plans. And that perspective would have been very helpful I believe for understanding why they would encourage the use of these grants but also, at the same time, call for a 40 percent cut to their funding.

As I am sure many of my colleagues today will underscore, substance abuse and its impacts on communities is nothing new. And if there is anything that we have learned from past failures in addressing this problem it is that resources do matter. In addition to investing in treatment and recovery programs at the back end, we must also address the poverty, the violence, poor healthcare, and inadequate education that can be contributing factors to unhealthy communities.

I look forward to hearing about what investments are needed to address a crisis of this magnitude without robbing other vital programs, such as family support services and job training that support families and communities.

I want to thank the witnesses for being here today. And I certainly want to congratulate Dr. Leana Wen on her newest addition to her family. I look forward to your testimony and hearing more about how we can address and help communities impacted by the opioid abuse exist its crisis.

Thank you very much for being here.

[The information follows:]

**Prepared Statement of Hon. Susan A. Davis, Ranking Member,
Subcommittee on Higher Education and Workforce Development**

As my colleagues have said, the opioid crisis has greatly impacted our communities. In 2015, more than 33,000 Americans died of an opioid overdose, and more than 2 million individuals had an opioid use disorder. In California, more people die from drug overdose each year than from auto-accidents.

That's why it's so important to continue to invest in the federal programs that promote addiction recovery and treatment.

Across the country and in California, Medicaid has been vital to addressing the opioid epidemic. Adults with Medicaid coverage are about three times more likely to have received treatment as inpatients, and almost twice as likely to have received outpatient treatment, than privately insured adults.

As Ranking Member Polis noted, in our efforts to combat this epidemic, it's vital that we invest in the systems and programs that support healthy families and communities. This means a strong workforce. As we've seen with past drug epidemics that have rocked our communities, the opioid epidemic has a strong link to jobs. According to recent research, an estimated 25 percent of the drop in women's work-

force participation between 1999 and 2015 can be attributed to the increase in opioid prescriptions. For men, that number is about 20 percent.

And we know that when adults, particularly women, aren't working, it has significant impacts on the economic security of families and communities beyond the immediate loss of income. For example, job loss for a parent can translate into lower wages and difficulty remaining in the labor market for their children later in life.

It's particularly important to note the relationship between opioid abuse and unemployment. This means that individuals may fall out of or have difficulty staying in the job force due to their dependence on opioids or may become addicted after job loss.

We must help individuals remain employed and break down barriers to individuals with substance use disorders re-entering the workforce. This means rethinking employer drug testing policies and using a more thoughtful approach to employment for those with involvement in the criminal justice system. We must also leverage our workforce development system to ensure our nation's workers, especially those in communities or industries impacted by trade and technology, have access to the jobs and skills development they need.

Integrating job training into recovery and treatment efforts is also key. Linking these services can be crucial for helping people re-enter the workforce and improve the probability of recovery efforts long term.

So I look forward to hearing about how our current system can be improved, including ideas on providing key services in the same location, or best practices for partnerships between the workforce development and health systems.

Now, we know that the Trump Administration has declared a Nationwide Public Health Emergency to address the opioids crisis. As part of this declaration, the administration has directed the Department

of Labor to use Dislocated Worker Grants "to help workers who have been displaced from the workforce because of the opioid crisis, subject to available funding."

Unfortunately, we will not be hearing from anyone from the administration today to get a better understanding of their plans. That perspective would have been key in understanding why they would encourage the use of these grants while calling for a 40 percent cut to this funding.

As I'm sure many of my colleagues today will underscore, substance abuse and its impacts on communities is nothing new. And if there's anything we've learned from our nation's past failures in addressing substance abuse issues and supporting impacted communities, it is that resources matter.

So I look forward to hearing about what investments are needed to address a crisis of this magnitude without robbing other vital programs, such as family support services and job training, that support healthy families and communities.

I would like to thank the witnesses for being here today. I also want to congratulate Dr. Leana Wen on the newest addition to her family.

I look forward to your testimony and hearing more about the how we can help communities impacted by the opioid abuse crisis.

Thank you.

Chairman ROKITA. And the gentlelady yields back. Pursuant to committee rule 7C all members of the subcommittees will be permitted to submit written statements to be included in the permanent hearing record. And without objection the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material reference during the hearing to be submitted for the official record.

We will now turn to the introduction of our distinguished panel of witnesses, and I yield to Chairman Guthrie to introduce our first witness.

Chairman GUTHRIE. First I would like to introduce Mr. Tim Robinson as the founder and CEO of Addiction Recovery Care, and it has 13 organizations that are networked through eastern and central Kentucky, and I talked about him in my previous remarks. So welcome, and I look forward to your testimony.

I yield back to the chairman.

Chairman ROKITA. Thank the gentleman. I yield to Ranking Member Polis for the introduction of the second witness.

Mr. POLIS. Thank you. I am honored to introduce Toni Miner. Miss Miner is a fellow Coloradan from Jefferson County, Colorado, which I have the honor of representing much of. She is currently working as a family support partner with the Jefferson County Child and Youth Leadership Commission. Prior to this position Toni Miner served as a family advocate with the Child and Youth Leadership Commission. She also worked as a parent partner for 5 years. In addition to mentoring families she also provides training to caseworkers on the ground. Court-appointed special advocate volunteers, she helps train as well. Miss Miner has been active in the Child Welfare System team decision-making meetings and serves on the Domestic Violence and Child Protection Services Coordinating Council. Welcome to our committee.

Chairman ROKITA. Thank you. I thank the gentleman and I will resume introducing our witnesses. Dr. Leana Wen is the commissioner of health for the city of Baltimore, Maryland. And Dr. David Cox is the superintendent of schools in Allegany County, Maryland. Welcome to all the witnesses.

[Witnesses sworn]

Chairman ROKITA. And let the record reflect that all witnesses answered in the affirmative.

Before I recognize each of you to provide your testimony let me briefly explain our lighting system, and it is a reminder for us up here as much as it is for you. You will each have 5 minutes to present your testimony. And when you begin the light in front of you will be turned green, when 1 minute is left it will be yellow, and when the time is expired the light will turn red. At that point I will ask you to wrap up your remarks. After everyone has testified members up here will each have 5 minutes to ask questions of each of you.

And so with that, let me recognize Mr. Robinson for 5 minutes. Thank you, sir.

TESTIMONY OF TIM ROBINSON, FOUNDER AND CEO, ADDICTION RECOVERY CARE

Mr. ROBINSON. Good morning. My name is Tim Robinson. I'm the founder and CEO of Addiction Recovery Care. As already mentioned, there were more deaths due to overdoses than car accidents last year, making addiction a public health crisis. The addiction epidemic is not just costing us thousands of lives, it is also threatening our economic security as employers struggle to find and retain employees who can pass the drug screen. In September, our Kentucky Chamber of Commerce CEO wrote an op-editorial that called addiction the number one economic concern in our State.

Everyone is looking for a silver bullet to the addiction crisis and there is no single intervention that alone is a silver bullet. Addiction recovery requires a whole person approach which starts with identifying those in addiction, intervening with treatment, investing in their economic future through education and workforce development, and inspiring them to join the effort to do for others what was done for me, help another person discover their destiny and work out their recovery.

I am thankful for the opportunity to speak to you because recovery is personal to me. I started drinking in my first year of law

school at the University of Kentucky to cope with my mom passing away from terminal lung cancer during finals. For the next 8 years I almost drank myself to death. Ten years ago, while I was a prosecuting attorney in Lawrence County, Kentucky, a court bailiff who was a recovering alcoholic and a pastor led me to a spiritual awakening at my desk. He became my sponsor, but he also became my pastor. And he carried me for a while and he walked with me and poured his recovery and his faith into me. Addiction recovery is personal to me because I am a survivor.

Two years later, I resigned as prosecutor, gave my law practice to my law partner, and in 2010, opened Karen's Place, a recovery center for women in eastern Kentucky. Since opening our first center we've realized that addiction is a disease that devastates all aspects of a person's life and that a holistic approach is crucial for long-term recovery. Addiction impacts someone's mind, body, spirit, and their purpose. And we've been determined to treat addiction medically, clinically, spiritually, and vocationally. And though our centers are led by an addictionologist and are nationally accredited, Alcoholics Anonymous has taught us that a spiritual awakening is the foundation of lasting recovery. In that tradition we've developed a spirituality program that inspires hope and offers those coming out of an addiction an opportunity to understand that God is the source to find hope, forgiveness, and redemption. Much like hospice care centers and Catholic healthcare systems we employ chaplains and pastoral counselors who work alongside our clinical staff. And though we consider the faith-based aspect of our centers to be the heart of our success, our spirituality program does not replace medical and evidence-based clinical practices. It's in addition to them and makes our care more comprehensive.

Treating the whole person has led to great success. Our clients stay in treatment for 60 to 70 days, compared to a national average of 25 to 30 days. This objective measure shows our residential centers to be twice as effective as the national average.

Readmission is another objective measure. Those in addiction who relapse most often return to the same center 40 percent of the time. Less than 10 percent of our clients readmit.

As we have built our treatment network we have had a great need for addiction treatment workers and we have created an internship program and issued a challenge. Clients who intern with us until their 1-year clean mark would be guaranteed a job. Today 70 of Addiction Recovery Care's 200 employees are graduates of our program. We formalized their internship program, becoming a State-certified peer support specialist training program. A peer support specialist is a recovering addict who has at least 1 year of sobriety. After a 40-hour class they become a Medicaid billable behavioral health practitioner and can provide those in addiction with peer support.

SOAR, an economic initiative in Kentucky's Fifth Congressional District, connected us with the Workforce Board Eastern Kentucky Concentrated Employment Program and their executive director, Jeff Whitehead. With the Workforce Board providing funding we partnered with Sullivan University to transform our internship program into a workforce development opportunity. Our program graduates become State-certified and earn a college certificate.

There's also soft skills development and professionalism in workplace ethics. They receive other skills such as CPR, first aid, and using a medical record, electronic medical record.

In 2016, we started our first class and 16 peer support specialists graduated in May of 2017. Out of the 16 graduates, 14 of them were at least 8 months clean and sober today, working full-time, paying taxes, and transitioning off of public assistance. These 14 people now have great purpose and meaningful careers. We now have more than 50 others in the academy today.

Prior to the academy 40 percent of our clients moved to our transitional program. After starting the academy, now 70 percent of our clients now choose to continue treatment, which means treatment—

[The statement of Mr. Robinson follows:]

Good morning. My name is Tim Robinson, Founder and CEO of Addiction Recovery Care.

There were more deaths due to overdoses than to car accidents last year making addiction a public health crisis. The addiction epidemic is not just costing us thousands of lives, it is also threatening our economic security as employers struggle to find and retain employees who can pass a drug screen. In September, our Kentucky Chamber of Commerce CEO wrote an Op Editorial that called addiction the number one economic concern in our state.

Everyone is looking for a silver bullet to our addiction crisis. There is no single intervention that alone is a silver bullet. Addiction recovery requires a whole person approach which starts with identifying those in addiction, intervening with treatment, investing in their economic future through education and workforce development, and inspiring them to join the effort to do for others what was done for me: help another person discover their destiny and walk out their own recovery.

I am thankful for the opportunity to speak to you because recovery is personal to me. I started drinking in my first year of law school at the University of Kentucky to cope with my mom passing away from terminal lung cancer during finals. For the next eight years, I almost drank myself to death. Ten years ago, while I was a prosecuting attorney in Lawrence County, Kentucky, a court bailiff who was a recovering alcoholic and pastor, led me to a spiritual awakening at my desk. He became my sponsor and my pastor. He carried me for a while; He walked with me and poured his recovery and his faith into me. Addiction recovery is personal to me because I am a survivor.

Two years later, I resigned as prosecutor, gave my practice to my law partner, and in 2010 opened Karen's Place, a recovery center for women in Eastern Kentucky. Since opening our first center, we have realized that addiction is a disease that devastates all aspects of a

person's life, and that a holistic approach is crucial for long-term recovery. Addiction impacts someone's mind, body, spirit, and purpose. We have been determined to treat addiction medically, clinically, spiritually, and vocationally.

Though our treatment centers are led by an addictionologist and are nationally accredited, Alcoholics Anonymous has taught us that a spiritual awakening is the foundation of lasting recovery. In that tradition, we have developed a spirituality program that inspires hope and offers those coming out of addiction an opportunity to understand that God is the source to find hope, forgiveness and redemption. Much like hospice care centers and Catholic healthcare systems, we employ chaplains and pastoral counselors who work alongside of our clinical staff. Though we consider the faith-based aspect of our centers to be the heart of our success - our spirituality program does not replace medical and evidence-based clinical practices - it is an addition to them and makes our care more comprehensive.

Treating the whole person has led to great success. Our clients stay in treatment for 60-70 days compared to a national average of 25-30 days. This objective measure shows our residential centers to be twice as effective as the national average. Readmission is another objective measure. Those in addiction who relapse most often return to the same center 40% of the time. Less than 10% of our clients readmit.

As we built our treatment network we have had a great need for addiction treatment workers. We created an internship program and issued a challenge: clients who interned with us until their 1 year clean and sober mark would be guaranteed a job. Today, seventy of Addiction Recovery Care's two hundred employees are graduates of our centers and products of our internship program.

We formalized our internship program by becoming a state certified Peer Support Specialist (PSS) training program. A Peer Support Specialist is a recovering addict who has at least one year of sobriety. After a forty-hour class, they become a Medicaid billable behavioral health practitioner and can provide those in addiction with peer support.

SOAR, an economic development initiative in Kentucky's 5th Congressional District, connected us with the workforce board Eastern Kentucky Concentrated Employment Program, and their Executive Director, Jeff Whitehead. With the workforce board providing funding, we partnered with Sullivan University to transform our internship and peer support program into a workforce development opportunity. Our program graduates become state certified and earn a college certificate. There is also soft skills development in professionalism and workplace ethics. They receive other skills such as CPR, first aid, using an electronic medical record, and HIPAA compliance that are transferable to other career paths especially in the medical field. In just one year, a person in addiction can go from an IV needle heroin user to employed and earning a living helping others follow their path of recovery.

In October 2016, we started our first class, and sixteen Peer Support Specialists graduated in May 2017. Out of the sixteen graduates, fourteen of them are at least eighteen months clean and sober, working full time, paying taxes and are transitioning off of public assistance. These fourteen people now have great purpose and meaningful careers. We now have over fifty more recovering addicts in the academy today. Some of the graduates have even been promoted to middle management, and others are continuing their education for careers such as counseling.

Prior to the Academy, 40% of our clients moved on to our transitional program. After starting the Academy, 70% of our clients now choose to continue treatment, which means treatment motivation has almost doubled for those who have been given a meaningful career opportunity. It has exponentially multiplied the success of our treatment outcomes as 85% of our first

academy class are at least 18 months clean and sober and employed as productive citizens today.

Vocational education as a part of the continuum of care for addiction treatment drives greater levels of success due to three major reasons: 1). When someone enters treatment and knows there is a second chance career path it inspires hope and increases treatment motivation, 2). The 12th step of AA informs us that sharing our recovery is one of the foundations of long-term sobriety. This concept suggests that finding purpose in helping others strengthens your recovery and helps you to continue to heal from addiction; and Finally, 3). Experiencing the dignity of work gives recovering addicts who have reentered the workforce a positive self-image, confidence and helps them to establish career goals and plan for their future. A great example of this is Vanessa Keeton. She was an IV-needle user who entered one of our residential centers and completed our internship program. She became a treatment center director while earning a college degree and purchasing her first home. Recently, she resigned as our HR director to focus on the business she started that now supports her family.

We are also seeing success in other vocational education programs such as our maintenance internship. We are in the process of adding automotive, culinary arts and welding certificate and apprentice programs.

The hope of America is not merely surviving. The hope of America is an opportunity to flourish. That is what our brothers and sisters in addiction need; an opportunity. An opportunity for treatment and vocational skill building that leads to a meaningful career path, and when the opportunity is given...I have seen us not just survive, but thrive.

Chairman ROKITA. Thank you, Mr. Robinson. I appreciate that very much. Miss Miner, you are recognized for 5 minutes.

TESTIMONY OF TONI MINER, FAMILY SUPPORT PARTNER

Ms. MINER. Good morning. I wish to thank the Committee on Education and Workforce for providing me with this opportunity to share my perspectives with you today.

My name is Toni Miner and I am a birth mother of three children, Mercedes, Jonell, and Spencer, and the legal guardian for my two grandchildren, Angel and Tavin. And we live in Jefferson County, Colorado.

My story is that of a mother who was heavily ruled by her addiction to methamphetamine. My meth use became daily in 1996 and continued until 2002. Unfortunately, my two beautiful daughters had to live through my active meth addiction. I didn't think my meth use really had an effect on my girls as I was providing a roof over their head, food on the table, and clothes on their backs. But what my daughters wanted and needed more than anything in this world was a clean and protective parent.

Now, during this time of my meth use I received many criminal charges that were due to my use. I had burned all my bridges and had no support and I really didn't see any way out of my addiction. Then I found out that I was pregnant. I had no idea what I was going to do or how to get clean, but knew that I had to. I had hit my rock bottom. Because I was finally ready to get clean I was able to take the first steps and stop my meth use with the support of my amazing caseworker and probation officer, who did not judge me, but encouraged me. My daughters returned to my care the day that I was released with the understanding that I would comply with the probation requirements and complete intensive outpatient treatment.

Today, almost 16 years later, I am still clean and actively involved in a recovery program. I have rebuilt relationships with family, made many new friends, and have many supports in my life. Unfortunately, my poor choices did take a toll on my two daughters who eventually became addicted to drugs. Today as a kinship care provider, I can make sure that my grandchildren are safe from any future harm.

Besides working to ensure that my own family is strong and safe, I also work to help families who are impacted via child welfare and struggling with addiction. Working as a family support partner in Jefferson County, Colorado, and also working in our Problem-Solving Court, which is our family drug court in Jefferson County, I am able to educate and empower struggling families with the skills and knowledge to navigate multiple systems and advocate for their own supports and connections within the community. I also work with families through facilitating a circle of parents and recovery group, which are specialized parent support groups designed to build protective factors in families, addressing substance abuse and the impact of trauma.

Through my personal experience and my work with families I am able to provide you with recommendations that I believe will help strengthen families, especially during the opioid crisis.

One, collaboration across agencies is a must to ensure that children and families are getting the right service they need efficiently. Families interact with multiple systems with their own requirements, processes, and it is essential that these systems work together to ensure families get the help they need. Law enforcement, child welfare, schools, mental health, housing, courts, hospitals, employers, substance abuse programs, and methadone clinics should all be part of the process to help strengthen families struggling with addiction.

Two, focus on the whole family. Addiction is a family disease. And if the whole family is not treated and provided the right supports history will continue to repeat itself, as it did within my own family. Families at risk respond best to supportive and strengths-based approaches. Both my child welfare caseworker and probation officer believed that I could change and become the strong, resilient, and healthy parent that I am today.

Three, educate our communities and families regarding substance abuse. Public service announcements must talk about link between substance abuse and mental health and include available resources for treatment. Children must be educated, especially prevention education of the children of adult addicts.

Four, partner with parents to work with other families before, during, or after involvement with the child welfare and court systems. We need to partner with parents like me who have learned from their own experiences and can help other families navigate complex systems and access services. Many States and local jurisdictions are implementing parent partner programs and finding this can be a very useful strategy to effectively engage parents in their child welfare cases and treatment. These voices are also important as they educate policymakers, administrators, frontline workers, and others interacting with families.

If we implement these recommendations and invest in families, the sky is the limit in what we can achieve together.

Thank you for your time.

[The statement of Ms. Miner follows:]

**Testimony for
U.S. House of Representatives Committee on Education and the Workforce
Joint Subcommittee on Early Childhood, Elementary, and Secondary
Education and Higher Education and Workforce Development**

**Washington D. C., November 8, 2017
Submitted by Toni Miner, Family Support Partner**

Introductory Remarks

- My name is Toni Miner and I am a birth mother of three children and the legal guardian for my two grandchildren. I reside in Jefferson County, Colorado. I am pleased to be here today as a strong parent advocate who believes that families must be supported.
- I wish to thank the Committee on Education and Workforce and the Subcommittees on Early Childhood, Elementary, and Secondary Education and Higher Education and Workforce Development for providing me with this opportunity to share my perspectives with you today. Thank you to Chairmen Rokita, Guthrie, and to Ranking Members Polis and Davis.
- I am here to talk with you about some insights that I have gained from my own life experiences with addiction and the child welfare system and my work as a family support partner and facilitator for Circle of Parents in recovery group.
- I want to briefly share my story and my work as a family support partner. I am making four recommendations that I believe will help to create strength in families.
 1. Collaboration across agencies.
 2. Focus on the family as a whole.
 3. Educate our communities and families regarding substance abuse.
 4. Partner with parents to work with other families before, during or after involvement with the child welfare and court systems.

Background— My Story

As I share a little of my story, you will see why I am urging you to act on these recommendations.

- I grew up in a home with violence and alcohol. To cope with this during my early years, I also got involved in using drugs and alcohol. I continued to use off and on throughout my twenties. Fall of 1996 is when everything changed for me and my daughters. We had suffered a traumatic event in our life and I went to meth to solve how I was feeling, or to not feel. My meth use became daily for me that year. Now I didn't see how it was affecting my daughters because I still took them to

school, provided a roof over their head, food on the table and clothes on their back. My disease convinced me that I was being a great Mom by providing for them. The one thing that they needed more than anything else in their life was a sober and protective parent. I couldn't give that to them. As time went on and my addiction grew deeper, I was no longer getting them to school like I should have been. Even when I was there, I wasn't there emotionally. Meth was giving me what I needed, (so I thought) but in turn it was taking everything away from my daughters, and from me. I loved them so very much and wanted to be better, but I couldn't, I was stuck in my disease. There wasn't a day that went by that I didn't love my daughters, as a matter of fact, on most days I used more to not feel the guilt and the pain of what my addiction (disease) had done to my family.

- Unfortunately, my two daughters had to live through my problems with substance abuse. As I struggled with my drug addiction issues my daughters were frequently moved in and out of placements with relatives and friends.
- Then I got raided by the police for possession and went to jail. I was devastated and didn't know how to get clean. I continued to make bad choices until I found out I was pregnant. So there I was - pregnant, scared, dealing with social services and facing a prison term of more than 30 years. By this time my daughters were eight years old and 14 years old. Thankfully I could plan in advance for my daughters to go into kinship care while I served my jail sentence.
- That's when I met a child welfare case worker who truly changed my life. Instead of telling me what a loser I was, he asked how he could help, how he could partner with me to get my children back and to stay out of prison! I looked at him in disbelief and I doubted he meant a word of what he said. But when he showed up in court to beg the judge to give me a chance, I looked at him and cried! Here was someone who truly cared about what happened to me!
- The judge was lenient and only sentenced me to 90 days in jail and six years of probation. Due to my good behavior, I only had to serve 60 days. My daughters were returned to my care the day that I was released with the understanding that I would comply with the probation requirements and complete intensive outpatient treatment. Along with continued work and support from my caseworker.
- This case worker became an amazing source of strength for me. He encouraged me to re-establish my relationship with my mom. I needed my mom to help me get clean. I believe that we all need our Mom in our life. I didn't have mine at the time due to my addiction and the pain that I had caused her. I had hurt her emotionally and financially. I needed my Mom to believe in me again, to help me with my girls, for moral support and help with transportation. To my surprise, my mom was there for me and still loved me very much and continues to do so to this very day.
- Getting clean was one of the hardest things that I have ever had to do. I had to attend different classes, complete regular drug screening and participate in many

appointments. I was given an opportunity to heal and knew that I would lose my children for good if I did not comply with all the requirements. Even though I was receiving the supports that I needed, my daughters were not. My daughters had suffered very severe trauma due to my addiction. I believe this contributed to their own addictions, as their trauma was never dealt with.

- Today, almost 16 years later, I am still clean and actively involved in a recovery program. I have rebuilt relationships with family. I have made many new friends. I have lots of supports in my life - church, my children's school, my neighbors and of course, my family. Each one helps me stay strong and determined to never again go where I once was. Not every day is perfect for me. Some days are very hard but I know now that I can make it.
- As I look back on the life I led then and the one I lead now, I realize that coming in contact with the judicial and child welfare system was not as bad as I thought it was at the time. I have learned a lot. My case worker and probation officer were so supportive and empowering. I doubt I would have survived as well without them. They showed me that creating and supporting strong parent partnerships was a critical part of their work in helping families be successful. They trusted me. They believed that I could change – that I could grow and that I could be a strong, resilient and healthy parent.
- Unfortunately, my poor choices did take a toll on my two daughters. Both girls followed in my footsteps and became addicted to drugs. My oldest daughter continues to abuse drugs and also has major mental health issues. When they were younger they didn't get services or education about how to understand their parents addiction (a disease) and strategies and steps to take to prevent their own addiction. They also didn't get the appropriate mental health services they needed after experiencing traumatic events.
- When I learned that my oldest daughter was unable to properly care for her two children, I brought them into our home and became a permanent kinship care provider for them. Today I am actively parenting my son Spencer together with my two grandchildren, Angel and Tavin. As a kinship care provider, I can make sure that my grandchildren are safe from any future harm. Part of my decision to be a kinship caregiver is because I wanted to avoid my grandchildren going into foster care.
- Kinship care providers are such an important piece to the opioid epidemic that we are facing. We open our homes and our hearts to the children of the addicts. By doing so children can still have the family connection that is so important to their success. Kinship care providers also need support from the community such as mental health centers, social services, financial, schools, respite care and any other systems that may be involved with the family. It is a lot for kin to take responsibility of children, but it can be successful if given the supports needed to ensure these placements are stable and supported. It's not easy being a kinship caregiver. With

the opioid epidemic, states and counties are seeing an enormous rise in the number of kinship caregivers, many of whom are much older than I am who are raising young children, and they need help to care for these children.

My Work as a Family Support Partner, Family Advocate, Educator and Collaborator on Systems Change for families with addiction and child welfare involvement

My life experiences have provided me with some amazing opportunities to help other families in various ways such as:

- Working as a Family Support Partner in Jefferson County, Colorado to educate families and help them advocate for themselves on how to get their needs met.. A Family Support Partner is a parent or caregiver who has faced and overcome many barriers. Because of their unique perspectives and personal experiences, they are in a position to assist other families facing similar challenges in navigating multiple systems and locating community resources. The goal of the family support partners is to empower each family with the skills and knowledge to advocate for their own supports and connections within the community, and identify the best ways to ensure their voice is heard by the professionals they work with.
- A Family Support Partner empowers families by providing impartial support during meetings (e.g. family engagement meetings, team decision meetings, school, court, therapy, etc.); assistance in identifying community and natural supports; and support planning to prepare for future crisis and emotional support.

I worked with a family who suffered from opioid addiction and helped them to find the light within themselves and navigate these systems. I attended court regularly with the mother and attended school meetings for the children. The mother expressed her gratitude to me for how I was supporting not just her but also her family, as addiction is a family disease.

Facilitating a Circle of Parents in Recovery Group:

- The model is based on the following network standards to guide group implementation:
- The groups utilize the mutual self-help support model.
- An educated group facilitator and parent leader facilitate the support groups.
- Open groups meet regularly and are offered at no cost to any participant.
- Children's Program or Childcare Available
- The group facilitator, parent leader and other group members are available to one another between group meetings.
- Group members are assured of confidentiality in a non-judgmental environment within the limits of the law.
- Community resource information that supports healthy family development is available to all group members.
- Builds positive peer support networks

- Prevents relapse and sustains recovery
- Prevents future child abuse or neglect.

We have partnered with Betty Fords Children's Center to educate our children group facilitators on their curriculum. This curriculum really helps children aged 6 to 14 years old learn that their parent's addiction and recovery is not their responsibility. They also learn about addiction itself. They learn about their feelings in regard to their parents addiction and how to heal and work through them. The children learn how to share their feelings, and that they are not alone.

- Facilitating Family Leadership Training Institute (FLTI) to help families become engaged in civics, and identify their leadership skills in their communities.
- Educating caseworkers, Court Appointed Special Advocate (CASA) volunteers and kinship care providers by sharing my story to help them understand that even with some of the toughest families that they come across there is indeed hope. We have conversations about partnering with the families that they are working with, to get to know the families so they can work collaboratively and to help them understand that there is not only one way to work with families, because every family is unique.
- Serving on various state and local committees such as:
 - Collaborative Management State Steering Committee
 - Child and Youth Leadership Commission, Juvenile Justice Subcommittee
 - Child and Youth Leadership Commission, Human Trafficking Subcommittee
 - Child and Youth Leadership Commission, Education Subcommittee
- Collaborating with numerous advisory groups such as the Casey Family Programs Birth Parent Advisory Committee (BPAC) and the Birth Parent National Network (BPNN) to help make system reform and support families.

Recommendations.

Based on my own experiences with my family and now as a Family Support Partner, I am recommending the following:

1. Collaboration across agencies is a must to ensure that children and families are getting the right services they need efficiently.

- Families interact with multiple systems with their own requirements, processes and it is essential that these systems work together to ensure families get the help they need. Law enforcement, child welfare, schools, mental health, housing, courts,

hospitals, employers, substance abuse programs and methadone clinics should all be part of the process to help strengthen families struggling with addiction.

2. Focus on the whole family

- Provide support groups for the whole family. Addiction is a family disease and if the whole family is not treated history will continue to repeat itself, as it did within my own family
- Circle of Parents are specialized parent support groups designed to build protective factors in families. Examples of current focus areas include: Recovery Support, Parents and Families affected by Substance Use, and Parents and Families Impacted by Trauma.
- For example, parents need to hear that everyone has frustrations and problems and that it's okay for them to reach out for help without it creating more problems for them. Parents get isolated and think they are the only ones feeling overwhelmed or too ashamed to ask for help.
- Speaking from my own experiences, families at risk respond best to supportive and strengths-based approaches. I really appreciated the support and the trust that I received from my child welfare case worker and probation officer. They both believed that I could change and become the strong, resilient and healthy parent that I am today.

3. Educate our communities and families regarding substance abuse.

- Public Service Announcements that talk about substance abuse and mental health and how they often go together, including available resources for treatment.
- Share success stories of the families that are successful.
- We must educate our children of their own risk of being addicted. I talk with my children about it often, because it is not something that they think about every day. We need to have a prevention education for the children of adult addicts.

4. Partner with parents to work with other families before, during or after involvement with the child welfare and court systems.

- We need to partner with parents like me who have learned from their own experiences and can help other families navigate effectively access services and complex systems. Many states and local jurisdictions are implementing parent

partner programs and finding that this can be a very useful strategy to effectively engage parents in their child welfare cases and treatment.

- I would have benefitted greatly from having a parent partner who could have talked with me and provided me with support and assistance to navigate these systems.
- The perspectives of parents like me are important if we are to truly achieve better outcomes for children, families and communities. Policymakers, administrators, front line workers, and others interacting with families need to listen and understand the experiences and needs of families directly as they make decisions that will impact lives.

If we implement these recommendations and invest in families, the sky's the limit in what we can achieve together. I strongly urge you to implement these recommendations.

Thank you for your time and I welcome any questions that you may have.

Chairman ROKITA. Thank you, Ms. Miner. Dr. Wen, you are recognized for 5 minutes.

**TESTIMONY OF LEANA WEN, COMMISSIONER, BALTIMORE
CITY HEALTH DEPARTMENT**

Dr. WEN. Chairmen Rokita and Guthrie, Ranking Members Polis and Davis, thank you for calling this hearing. I am here as an emergency physician and the Health Commissioner of Baltimore where overdose claims the lives of two residents a day and where addiction affects every aspect, from the workforce to our youngest children.

Baltimore has a three pillar approach. First, we focus on saving lives by making the opioid antidote, naloxone, or Narcan, available to everyone. Not only have we equipped paramedics and the police, I issued a blanket prescription to all 620,000 of our residents. Since 2015, every day individuals have saved the lives of 1,500 people. But we have a problem. Our city is out of funds to purchase naloxone, forcing us to ration and make decisions every day about who can receive the antidote. At a time of a public health crisis it is unconscionable that we are being limited in our ability to save lives.

Our second pillar is to increase on-demand addiction treatment. The science is clear: addiction is a disease, treatment exists, and recovery is possible. Nationwide only 11 percent of patients with addiction get treatment. Imagine if only 1 in 10 people with cancer can get chemotherapy. Yet, my patients come to the ER asking for help and I tell them they must wait weeks or months. I have had patients overdose and die while they are waiting because our system failed them.

In Baltimore, we started a 24/7 phone hotline that includes immediate access to a social worker or addiction specialist. We receive 1,000 calls a week. We are starting a 24/7 ER for addiction and mental health.

We believe that treating addiction as a crime is unscientific, inhumane, and ineffective. That's why we have programs like LEAD, Law Enforcement Assisted Diversion, where individuals caught with small amounts of drugs will be offered treatment instead of incarceration.

Law enforcement to stop the trafficking of drugs is important as is more judicious prescribing by doctors. However, reducing the supply of drugs will not work unless there is equal attention to curbing demand through providing treatment. That means the Federal Government should do everything possible to expand insurance coverage. One in three patients with addiction depend on Medicaid. If Medicaid were gutted and they were to lose coverage many more would overdose and die. Other patients on private insurance could find themselves without access to treatment if addiction is no longer required to be part of their health plan.

Essential health benefits are called essential for a reason, and all insurance plans should cover preventive care and evidence-based addiction services, including the gold standard, which is medication-assisted treatment. Block grants should not replace insurance coverage because no disease can be treated through grants alone.

We on the front lines know what works. We have done a lot with very little, but this is a national emergency. We desperately need new resources, not repurposed funding that will divert from other critical priorities. These funds should be given directly to communities of greatest need. Cities and counties have been fighting the epidemic for years and we should not have to jump through additional hoops, like competing for grants and having funding pass from the States to cities. That will cost time and more lives.

Our third approach is to reduce stigma and prevent addiction. We have trained all of our nurses in our 180 public schools to save lives with naloxone and we now have addiction and mental health services in 120 of our schools. Opioid addiction affects those even younger. More than half of children who die in Baltimore have a parent or a caregiver with addiction and mental health concerns. Home visiting for pregnant women helps to identify families in need of treatment and support. This is a key component of our city-wide strategy, B'more for Healthy Babies, which has successfully reduced infant mortality by nearly 40 percent in 7 years. The opioid crisis requires proven public health approaches spanning the entire life course.

In closing, we know what works. We need support from the Federal Government with three actions. First, protecting and expanding insurance coverage to get to on-demand treatment for the disease of addiction. Second, allocating additional funding to areas hardest hit by the opioid epidemic directly to local jurisdictions. And third, supporting early interventions for women, children, and families. By the time this hearing is over at least 10 more people will have died from overdose. I urge Congress to commit the additional resources needed to save lives and reclaim our communities.

I thank you for calling this hearing.

[The statement of Dr. Wen follows:]

CITY OF BALTIMORE
CATHERINE E. PUGH, Mayor



HEALTH DEPARTMENT
Leana S. Wen, M.D., M.Sc., FAAEM
Commissioner of Health
1001 E. Fayette St.
Baltimore, MD 21202
health.commissioner@baltimorecity.gov
Tel: 410-396-4387

November 8th, 2017

TO: Committee on Education and the Workforce: Joint Subcommittee on Early Childhood, Elementary, and Secondary Education and Higher Education and Workforce Development

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Testimony: "Close to Home: How Opioids are Impacting Communities"

Subcommittee Chairmen Rokita and Guthrie, Subcommittee Ranking Members Polis and Davis, Chairwoman Foxx, Ranking Member Scott, and Distinguished Members of the Committee and Subcommittees:

Thank you for inviting me to testify on the epidemic of opioid abuse that is sweeping across our country. Opioid abuse is a public health emergency that is claiming the lives and livelihoods of our citizens. It affects the entire life course, and touches upon every aspect of our communities, from public safety to the workforce to children and families.

As an emergency physician, I have witnessed firsthand the effects of substance addiction, including treating hundreds of patients who have overdosed on opioids. I remember well my patient, a 24-year old mother of two who came to the emergency room (ER) nearly every week requesting addiction treatment. She would be told there was nowhere for her to go that day or the next, and would be offered an appointment in three weeks' time. Because she lacked housing and other supportive services, she would relapse. One day, her family found her unresponsive and not breathing. By the time she arrived in the ER, it was too late for us to save her, and she died.

I always think back to my patient now: she had come to us requesting help, not once, not twice, but over and over again, dozens of times. Because we do not have the treatment capacity, people looking to us for help fall through the cracks, overdose, and die. Why has our system failed her, just as it is failing so many others who wish to get help for their addictions? How does our system continue to fail her family? Nationwide, 2.5 million children are raised by grandparents and other relatives, with parents missing—and that number is rising, in part because of the epidemic of opioid addiction. After a long period of decline, the number of children in foster care is rising for the same reason.

My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, society had missed significant opportunities to intervene further upstream in that individual's life. We treat addiction differently than we treat any other illness. Would we ever tell someone who has had a heart attack to wait three weeks to get treatment? Despite scientific studies showing that addiction is a disease and that recovery is possible, many

still question why people “choose” a lifestyle of using drugs. Would we impose such stigma on any other disease? How can we intervene early—not just when someone is dying from an overdose, but much earlier, to prevent addiction in the first place and to provide treatment for people the moment they need it? These are the experiences that drove me to public health: a desire to tackle the epidemic of addiction at a community-level, and in doing so, save lives while also redefining our societal approach to the treatment of addiction.

As the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Health Department and partners across our city to prevent overdose and stem the tide of addiction. These partners include our local behavioral health authority, Behavioral Health System Baltimore, whose board I serve on as the Chair. I am encouraged that the approach to the opioid epidemic is shifting away from the rhetoric of the “war on drugs” and instead focusing on treating addiction as a disease. But while our rhetoric is changing, funding for treatment lags behind. Of the more than 25 million people who abuse some form of drug, only about 1 in 10 is able to receive treatment. Ensuring those struggling with addiction can access treatment on-demand requires urgent funding and support from the federal government.

The Opioid Problem in Baltimore

With over 21,000 active heroin users in Baltimore and far more who misuse and abuse prescription opioid medications, opioid addiction and overdose is a critical health priority in our city. In 2016, 694 people died from drug and alcohol overdose, which is more than twice the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us—our neighbors, our friends, and our family.

Baltimore’s Response to Addiction and Overdose

Our work in Baltimore is built on three pillars:

- First, we have to prevent deaths from overdose and save the lives of people suffering from addiction.
- Second, we must increase access to quality and effective on-demand treatment and provide long-term recovery support.
- Third, we need to increase education and awareness in order to reduce stigma and encourage prevention and treatment.

1. Preventing deaths from overdose

In 2015, I declared opioid overdose a public health emergency and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country.

- a. The most critical part of the opioid overdose prevention campaign is expanding access to naloxone – the lifesaving drug that reverses the effect of an opioid drug overdose. Naloxone is safe, easily administered, not addictive, and nearly 100% effective at reversing an overdose. In my clinical practice as an emergency physician, I have

administered naloxone to hundreds of patients and have seen how someone who is unresponsive and about to die will be walking and talking within seconds.

Since 2003, Baltimore City has been training drug users on using naloxone through our Staying Alive Program. In 2015, we successfully advocated for a change in State law so that we can train not only individuals who use drugs, but also their family and friends, and anyone who wishes to learn how to save a life. This is critical because someone who is overdosing will be unresponsive and friends and family members are most likely to help.

In 2017, we further amended the state law to eliminate the training requirement for obtaining naloxone. Today, naloxone is now essentially available over the counter in Baltimore. Anyone can walk into any pharmacy and obtain naloxone under my blanket prescription.

Our naloxone education efforts are extensive. Since 2015, we trained nearly 30,000 people to use naloxone: in jails, public housing, bus shelters, street corners, and markets. We work with businesses, libraries, restaurants, and other entities to conduct outreach and education, and go to where people are.

We were one of the first jurisdictions to require naloxone training as part of court-mandated time in Drug Treatment Court. We have trained federal, state and city legislators so that they can not only save lives, but also serve as ambassadors and champions to their constituents.

- b. We use up-to-date epidemiological data to target our training to “hotspots,” taking naloxone directly into the most at-risk communities and putting it in the hands of those most in need. This was put into effect in 2015, when 39 people died from overdose of the opioid Fentanyl between January and March of 2015. In 2016 we lost 419 people to a Fentanyl overdose; the numbers continue to escalate, and there are now 50 times the number of people dying from Fentanyl than there were in 2013. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. These data led us to target our messaging so that we could save the lives of those who were at immediate risk. Through our citywide Fentanyl Taskforce, we coordinate our data with agencies across the city, including the police department, fire department, and hospitals, to ensure our information is complete and our efforts are unified.
- c. In order to train even more people in the use of naloxone, we have launched an online platform that now allows residents to get trained online and immediately receive a prescription for naloxone. This online platform, which is the first-of-its-kind around the country and the world, is the next step to reduce barriers to the use of naloxone.
- d. Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to train police officers who have since saved

182 lives. The initial trainings were met with resistance from the officers who were hesitant to apply medical interventions that some did not see as part of their job description. However, in the first month of carrying naloxone, four police officers used it to save the lives of four citizens. After those involved acclimated to the change, I attended a training where I asked the officers what they would look for if they were called to the scene for an overdose. In the past, I would have received answers about looking for drug paraphernalia and other evidence. This time, officers answered that their job was to find out what drugs the person might have taken, call an ambulance, and administer naloxone, because their duty is to save a life. By no means is naloxone training the panacea for repairing police and community relations. However, it is one step in the right direction as we make clear that addiction is a disease and overdose can be deadly. We are changing the conversation so that all of our partners can join in encouraging prevention, education, and treatment.

- e. We successfully advocated for Good Samaritan legislation, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone.
- f. Our state Medicaid program has agreed to set the co-pay for naloxone at \$1. While we still struggle with the pricing for naloxone (see below), this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life—which we believe is each and every one of us.

Some people have the misconception that providing naloxone will only encourage a drug user by providing a safety net. This dangerous myth is not rooted in science but in stigma. Would we ever say to someone whose throat is closing from an allergic reaction, that they shouldn't get epinephrine because it might encourage them to eat peanuts or shellfish? An Epi-Pen saves lives; so does naloxone, and it should be just as readily available. Our mantra is that we must save a life today in order for there to be a better tomorrow.

2. Increasing access to on-demand treatment and long-term recovery support

Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure there is adequate access to on-demand treatment. Nationwide, only 10% of patients with addiction get the treatment they need. There is no physical ailment for which this would be acceptable—imagine if only 10% of cancer patients or 10% of patients with diabetes were being treated. If we do not increase access to quality treatment options we are merely treading water, waiting for the person who has overdosed to use drugs and overdose again.

The evidence is clear: addiction treatment requires a combination of medication-assisted treatment, psychosocial support, and wrap-around services including supportive housing. All of these must be in place for individuals suffering from addiction to recover, and they must be available at the time the individual is seeking these services—the same as for any medical

condition. There are three FDA-approved medications (methadone, buprenorphine, and naltrexone). All three should be available and covered by insurance equally in all places where people are seeking treatment.

- a. In Baltimore, we have started a 24/7 “crisis, information, and referral” phone hotline that connects people in need to a variety of services including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services and information. This hotline is not just for addiction but for mental health issues; behavioral health issues are so closely related, and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line receives approximately 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by schoolteachers and family members seeking resources, and police and providers looking to connect their patients to treatment.
- b. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. SBIRT is now being implemented in nine of our eleven hospitals and in our city clinics to ensure delivery of early intervention and treatment services for those with or at-risk for substance use disorders.
- c. We have piloted a real-time treatment dashboard to obtain data on the number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment. This enables us to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard is being connected to our 24/7 hotline that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.
- d. We have secured \$3.6 million in capital funds and \$2 million in operating funds for a “stabilization center”—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 “Urgent Care” for addiction and mental health disorders—a comprehensive, community-based “ER” dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must also be able to seek treatment on-demand. This center will enable patients to self-refer or be brought by families, police, or EMS—a “no wrong door” policy ensures that nobody would be turned away. The center would provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings, and connect patients to case management and other necessary services such as housing and job training.
- e. We are expanding and promoting medication-assisted treatment, which is an evidence-based and highly effective method to help people recover from opioid addiction. This combines behavioral therapy with FDA-approved medications. Taking medication for

opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction. Rather, it manages a patient's addiction so that they can successfully achieve recovery. Baltimore has been at the cutting edge of innovation for incorporating medication-assisted treatment, including providing medications in structured clinical settings. Last year, we expanded access to buprenorphine treatment by offering services in low-barrier settings, such as recovery centers, emergency shelters, and mental health facilities. This year, we are looking to double the number of physicians who are able to prescribe buprenorphine, and to begin buprenorphine induction in other settings including our city clinics and ERs. Providing access to buprenorphine services allows us to engage more people into much needed treatment.

- f. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. To build trust, these individuals have been recruited from the same neighborhoods as individuals with addiction, and are trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services. To date, eight of eleven hospitals participate in our Overdose Survivors Outreach Program, in which overdose survivors in the emergency room are linked with peer recovery coaches in the community. These peers work with patients after they are discharged to provide a “warm hand-off” into treatment and other support services.
- g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, more than 75,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an addiction.

Baltimore already has highly-effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts. At the start of 2017, we began implementing a Law Enforcement Assisted Diversion Program (LEAD), a pilot model that has been adopted by a select group of cities. LEAD establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing – rather than to central booking for arrest. Cross agency partnerships will be key in making these programs successful. LEAD implementation in Baltimore involves not only the Health Department and our behavioral health providers but the Police Department, State's Attorney's Office, Public Defender's Office, and many more entities that together recognize the importance of addiction treatment.

- h. We are increasing our capability for case management services for every individual leaving jails and prisons. These individuals are in a highly vulnerable state, and must be linked to appropriate physical and behavioral health care, social and supportive services, employment, mentoring and housing. Our outreach workers already target a subset of this

population; we need to expand capacity to every one of these individuals. Additionally, we are deploying community health workers who are individuals in recovery themselves. Based in the communities in which they work, they are “credible messengers” who reach people where they are. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

3. Providing education to reduce stigma and prevent addiction

In addition to treating patients, we must also change the dialogue around the nature of substance use disorders while we work towards preventing addiction. This effort has multiple components, including educating doctors and the public, and providing prevention and early intervention services throughout the life course.

- a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign, “DontDie.org,” to educate citizens that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches, all coordinated with neighborhood leaders. We work with restaurants and bar owners to post “Don’t Die” posters in their establishments. “DontDie.org” has also become our portal for online trainings and for the dispensing of naloxone through the Standing Order mentioned above. Any resident can watch a short (10 minute) video, take a four-question quiz, and have completed the training.
- b. We have established permanent prescription drug drop boxes at all nine of the city’s police stations and have conducted educational awareness campaigns around not using prescriptions that were given to anyone else. Anyone can drop-off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. More than half of 12 to 17 year-olds who misuse prescription opioids say they got them from a friend or family member. Despite this, half of all patients prescribed opioids report receiving no instructions about safe storage and disposal.
- c. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control and Prevention (CDC), there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid bottle for every adult American. Every day, people overdose or become addicted to their prescription opioids.

To address this, I have sent “best practice” letters to every doctor in the city. These letters addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first-line medication for acute pain, and emphasizing the risk of addiction and overdose with opioids. We emphasize adherence to CDC guidelines. Importantly, this best practice requires co-prescribing of

naloxone for any individual taking opioids or at-risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone if they are to be discharged with opioid medications that can result in overdose.

These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds, medical society conferences, and have also launched physician “detailing,” where we deploy teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working on a convening for pharmacists to set pharmacy best practices, and have supported statewide legislation to require the use of Prescription Drug Monitoring Programs by physicians and pharmacists. All of us—as providers, patients, and family members—must play our part to prevent addiction and overdose.

- d. We recognize that education must begin as early as possible, and that our schools are a critical part of our efforts. We launched a concerted effort to target prevention among our teens and youth through a campaign called “BMore in Control!” We are also incorporating prevention into the public school curriculum. As of 2017, Maryland state law requires schools to teach on addiction. We are working with our school district to implement evidence-based educational curricula.
- e. We have trained all of our nurses in our 180 public schools to save lives with naloxone. We now have addiction and mental health services in 120 of our schools. These efforts are a good start, but are limited for two reasons. First is the issue of billing: certain critical services such as case management and care coordination are not reimbursable, yet these are key to identifying children in need. Second is that there must be a focus on a true prevention intervention model. Substance use is often not the problem but a response to trauma, and there must be a more comprehensive approach to social and emotional learning and to addressing intersecting issues such as poverty, violence, racism, and trauma.
- f. A guiding principle in public health is to intervene as early—and as “upstream”—as possible. This is particularly salient given the statistics that show that the number of babies born addicted to drugs has tripled between 1999 and 2013. In some places, up to 40% of NICU costs are from babies with neonatal abstinence syndrome. In Baltimore, more than half of children who die have a parent or caregiver with addiction and mental health concerns.

Home visiting for pregnant women helps to identify families in need of treatment and support. Becoming a parent is one of life’s most rewarding experiences—and also one of its most difficult. I am a new mother to an 11-week old baby. My son and I are healthy, and I am privileged to have many resources available to me, including excellent health insurance and many social supports. Even so, learning to care for a newborn has been very hard. Many new mothers face significant obstacles, including stress, poverty, trauma, and social isolation, and physical and mental health issues. Home visiting has been shown to be an evidence-based, effective method of supporting families.

In our experience, home visitation identifies issues ranging from lack of resources to purchase cribs (in which case, we help to supply them); to homes with peeling paint and allergy- and asthma-inducing molds (in which case, we work with other city agencies to remediate homes to prevent lead poisoning and asthma exacerbations); to other social issues that could have otherwise resulted in serious harm such as domestic violence and substance use disorders.

Home visitation is a key component of our citywide strategy, B'More for Healthy Babies, which has successfully reduced infant mortality citywide by nearly 40% and sleep-related infant deaths by 70% in 7 years. B'More for Healthy Babies has more than 150 partners around the city who work to provide support and resources for women, children, and families. These supports include identification and connections to behavioral health treatment and housing assistance.

Despite the success of strategies like B'More for Healthy Babies, this and other programs that focus on upstream, early interventions are chronically underfunded. Such programs are evidence-based and cost-effective. They are necessary to break the cycle of intergenerational poverty and addiction. Studies have shown that children who grow up with family members who have substance use disorder are themselves much more likely to develop substance use disorder.

Critical to programs like these are care coordination services to identify and conduct outreach to women and families and need. Home visitation is most effective when it is combined with a continuum of care services such as child development and other family services in the community. These programs and the connections to care must also be significantly expanded.

- g. In August 2017, the Baltimore City Health Department was informed that our grant from the Department of Health and Human Services' Office of Adolescent Health was to end early. This grant funds sexual health education and outreach programming, promoted through our "U Choose, Know What U Want" campaign. With a total cut of \$3.5 million, this will affect 20,000 youth in our city.

This program is much more than about sex education in schools. It is an integrated effort to reduce the city's teen pregnancy rate and to empower girls and women. It provides needed education, connection and services, including to behavioral health providers. It helps to break intergenerational poverty and trauma. Programs like these must be recognized as a key component to reducing and preventing addiction, and should be funded and expanded.

Working with the Federal Government:

The Baltimore City Health Department, together with our partners across the city and state, has made significant progress in tackling the opioid epidemic. However, there are some areas where

we face continued challenges. Though there is much that can be done on the city- and state-levels, the federal government also plays a critical role.

Congress has shown clear concern for this pressing tragedy, including through the passage last year of the Comprehensive Addiction and Recovery Act. There is also increased recent attention to the crisis by President Trump's declaration of a limited public health emergency.

There are three specific areas that we urge for this Committee to consider:

1. Congress must protect and expand insurance coverage for on-demand addiction treatment.

One in three patients with substance use disorders depend on Medicaid. If Medicaid were gutted and they were to lose coverage, there is no margin of error: the only option for millions might be to use drugs, and potentially overdose and die. Other patients on private insurance could find themselves without access to treatment too if addiction is no longer required to be part of their health plan.

The federal government needs to protect and expand Medicaid and require that all insurance plans cover evidence-based addiction treatment. Essential health benefits are called essential for a reason, and all insurance plans should cover preventive care and addiction and mental health services. There should also be coverage for wraparound services that are critical for treating addiction, such as connections to treatment, coverage for supportive housing, and reimbursement for peer recovery specialists.

Block grants should not replace insurance coverage, because no disease can be treated through grants alone.

2. Congress should urgently allocate new funding directly to local jurisdictions hardest hit by the opioid epidemic.

While states have traditionally received block grants from the federal government, local jurisdictions are the closest to the ground in service delivery, and understand the needs of residents the best. We urge Congress to consider direct support for local jurisdictions, particularly those in areas of greatest need, by providing cities and counties with the autonomy to innovate and provide real-time care for our residents.

Baltimore is in dire need for more funding to purchase the opioid antidote, naloxone. Naloxone is part of the World Health Organization's (WHO) list of essential medications. It is available as a generic, yet both the generic version as well as brand-name versions are too expensive for local jurisdictions to afford with their limited budgets.

In Baltimore, not only have we equipped paramedics, EMTs, and the police with naloxone, my blanket prescription equips every resident in our city to carry naloxone. Since 2015, we have trained 30,000 people, and everyday people have saved the lives of nearly 1,500 of their fellow residents.

But we have a problem: our city is out of funds to purchase naloxone, forcing us to ration and make decisions every day about who can receive this antidote. This issue is particularly acute because of Fentanyl. The number of people dying from Fentanyl has increased 50-times since 2013, and because of how strong Fentanyl is, we need more naloxone to revive individuals who are overdosing.

Last month, Representative Elijah Cummings led a coalition of 51 members to call for the President to negotiate directly with manufacturers of naloxone. We urge for these negotiations to occur—imagine how many more lives we can save if we had the resources to do so. In the short-term, we need many more resources to purchase this life-saving medication. If our city receives funding today, we can immediately translate it into saving lives through purchasing naloxone and through expanding treatment access.

For years, we on the frontlines have been able to do a lot with very little. We need resources from the federal government to help us—new resources, not repurposed funding that will divert from other critical health priorities. These funds should be directly given to communities of greatest need. Cities and counties know what works, and local officials should not have to jump through additional hoops to obtain the resources we need. Issuing grants and having local jurisdictions compete for them will cause months if not years of delay, as would funding that passes through the states before getting to cities and counties.

3. Congress should support and fund early interventions for women, children, and families.

Upstream, early interventions such as home visitation and school-based supports are evidence-based and cost-effective. A recognition of substance use as not the cause but as a response to trauma, poverty, and violence calls for early investments in our women, children, and families.

To mitigate the impact of addiction on families and to prevent future addictions from occurring, educational campaigns are not enough. They must be combined with social support interventions, including home visitation and care coordination programs.

Congress should immediately reauthorize funding for the Children’s Health Insurance Program, as well as fully fund and expand evidence-based home visitation funding for programs such as Healthy Start, Healthy Families America, and Nurse Family Partnerships. Additional support should be given to expand whole-family, multi-generational approaches such as Early Head Start. Congress should also urge the Department of Health and Human Services to restore funding for teen pregnancy prevention and expand similar holistic approaches that empower girls, women, and families.

Conclusion

While some of the challenges facing Baltimore are unique, we join our counterparts around the country in addressing the epidemic of opioid abuse and addiction. According to the CDC, the number of people dying from overdose has quadrupled from 15 years ago. In many states, there are more people dying from overdose than from car accidents or suicide. This crisis extends far

beyond the individual suffering from addiction; it ties into the very fabric of society and has impacts across the life course and for generations to come.

There are some who say the opioid problem is too big and too complicated—that it cannot be solved. It is true that treating the opioid epidemic requires many approaches. However, this is a problem with a solution—if only we have the will and commit the resources. Treating addiction is not only the humane thing to do, it is also cost-effective. According to the NIH, treating opioid addiction saves society \$12 for every \$1 spent on treatment. Treatment also impacts communities by reducing excess healthcare utilization, increasing productivity and employment rates, and decreasing poverty and unnecessary cost to the criminal justice system. Furthermore, treating addiction is a moral imperative and a matter of life and death.

I'd like to end with one final plea: imagine if a natural disaster like a hurricane were claiming 142 lives a day. No one would question the resources required to repair houses and rebuild infrastructure, and billions of dollars would immediately be appropriated. The opioid epidemic can be solved if we commit a similar level of resources with urgency, compassion, and action. I urge Congress to put the full weight of the federal government to stem the tide of this epidemic, and to join those of us on the frontlines to commit the necessary resources to save lives and reclaim our communities.

I want to thank you for calling this important hearing. I look forward to working with you to stop the epidemic of heroin and opioid addiction in the United States.

Chairman ROKITA. Thank you, Doctor. Dr. Cox, you are recognized for 5 minutes.

TESTIMONY OF DAVID COX, SUPERINTENDENT, ALLEGANY COUNTY

Dr. COX. Good morning, Chairmen Rokita and Guthrie, and Ranking Members Polis and Davis. Thank you for the invitation to be here today to share the very deep impact of a real struggle affecting our district, students, and our community. As stated, I am the superintendent of schools in Allegany County, which is located in western Maryland, where it's been my honor to serve as its superintendent since 2009.

Just a few quick facts about Allegany County. The median income is just over \$40,000. The population there is about 72,000. Our current student enrollment is 8,700. Our free and reduced meal population in the school system is 55 percent. Countywide, our special education population is 16 percent. And according to our sheriff this year to date there have been 27 overdose deaths in our county. Last year there were 59.

Today I want to share the impact of opioid abuse that affects my students each day and the dramatic change that I've witnessed in just the past 5 years, and with each successive year getting progressively worse.

One of the first was a decline in our attendance and parental involvement in the child's schools. We work very hard as a priority of our local board to provide every child in our county with a high-quality preschool experience in our district and to identify the learning needs of children as early as possible. In doing so, we've experienced a sharp increase in the number of children who require special services due to the opioid issues.

Eighteen percent of all newborns in Allegany County are born drug affected. And this statistic does not include those children who may have prolonged prenatal exposure to alcohol. Last year we experienced multiple occasions where parents overdosed and died in their homes while their young children were present. On two different occasions during the preschool home visits our staff encountered young children who answered the door, and each of those times when asked where their mother is the child said she's asleep. And when further investigated one of the mothers was deceased and the other was brought back through the use of Narcan.

In one particularly sad and impactful occasion last school year we had a kindergarten student who came to school on a Monday morning after staying with her father over the weekend. When she got to school she was sick and she had a fever. The school nurse tried to call the mother since the custody schedule indicated that the mother was the Monday caregiver. When the mother did not answer the phone, the school's secondary emergency contact was her grandfather who was contacted and he picked her up for medical attention. No one could have imagined that this child's mother and the mother's boyfriend had overdosed in the mother's home, at which time the boyfriend's also 5-year-old son was in the home and not in school. When the little boy ran out of food in his home he went to neighbors' houses and knocked on doors for food, which led to the discovery then that the little girl's mother and the boyfriend

were dead from an overdose of fentanyl. It was estimated by our authorities that the mother and boyfriend had been dead for 2 days.

My elementary principals have shared with me this year that they're experiencing more and more incidents of children who have severe behavioral issues when they enter school. Some of our pre-school age and kindergarten students require full-time adult support just to manage their behavioral issues as they work with individual behavioral support plans and often there is limited parental support.

The good news in all of this is that for many of our children who have been so impacted their public school is the place that they are the most loved, the best cared for, and where they receive the best nutrition, they're the warmest, and where they're shown the most kindness. And for this I am grateful to our caring teachers and schools and staff members, where they can grow and learn.

Allegany County Public Schools has revised its health curriculum to include specific information for students regarding substance abuse at all grade levels. We have particularly focused on the high school level on the prevention of opioids where we have enlisted the help of two recovering opioid addicts who give presentations to students in high school health classes. All schools are now stocked with naloxone and staff members know how to administer the opioid antidote to persons who are believed to have overdosed.

While I do appreciate that President Trump has recently recognized opioids as a national crisis, it is my hope and plea that our Federal Government will allow flexibility in use of Federal funds to allow school districts to utilize resources to help with our efforts to combat this crisis and to tend to the many unmet needs of our children. There is a good opportunity that Title IV funds in the new ESSA regulations could provide some of those flexibilities.

I have great difficulty in finding the words to describe the magnitude of the unmet mental health issues and the health issues of my students and families. Many are self-medicating their depression and anxiety and many suffer from generational addiction. Others have become addicted to prescription pain medicine and migrated to opioid addictions. Others, our children, are left with deep emotional scars when they lose the parents due to overdoses and there aren't enough resources to provide all the needs for counseling, therapy, and treatment. Keeping options open for children's health insurance programs is a critical need.

I want to express my sincere appreciation and opportunity to be here today. And if there is anything that I can do or AASA, we would certainly be glad to have you contact us.

[The statement of Dr. Cox follows:]

Draft Testimony to the House Committee on Education and Workforce

David A. Cox, Ed. D., Superintendent, Allegany County Public Schools

November 8, 2017

I. Introduction of myself and Allegany County and ACPS

Good morning, Chairmen Rokita and Guthrie and Ranking Members Polis and Davis. Thank you for the invitation to be here today to share the deep impacts of a very real struggle affecting our district's students and our community. My name is Dr. David Cox, and I am the Superintendent of Schools in Allegany County, Maryland, which is about 2 and a half hours Northwest of Washington, DC. It has been my honor to serve as Superintendent since 2009, now in my 9th year in that role.

At one time, Cumberland was the second largest city in Maryland, second only to Baltimore, and at our largest in 1971, we had a student enrollment of about 19,000 students. Today, our enrollment is about 8,700 students. The decline in enrollment is largely attributed to the departure of large manufacturing companies such as Kelly Springfield Tires, AFG Glass, Bayliner, and many more large scale manufacturers.

According to the US Census Bureau, the median income in Allegany County is just over \$40,000 per year, and in 2016 the population was estimated to be about 72,000, which is down from about 75,000 in 2010. Our county is about 425 square miles and is nestled in the Appalachian Mountains. From Cumberland on the Potomac River traveling west to Frostburg, in just about 12 miles, the elevation climbs about 1200 feet, creating another climate zone.

With the shuttering of so many manufacturers, we have also had to close and consolidate many schools over the years. Likewise, the real estate market has a surplus of available housing, and there is an abundant supply of affordable housing on the rental market.

Cumberland and Allegany County is primarily accessed via Interstate 68, from the east, connecting to Interstate 70, west of Hagerstown, Maryland, and we are about an hour east of Morgantown, West Virginia, on Interstate 68.

Today, our Free and Reduced meal population is about 55% countywide, with schools in the City of Cumberland having over 90%. Our Special Education population is about 16% of our total enrollment.

II. Summary of the Opioid Crisis in Allegany County and impacts to our students and their families, and our school communities

Cumberland and Allegany County is testament to the fact that the devastation of the opioid crisis is not contained in America's large cities. It also devastates suburban and rural America.

According to Allegany County Sheriff, Craig Robertson, so far this year there have been 27 overdose deaths in our county.

Today, I wanted to tell you how impactful this crisis is to my children who attend Allegany County Public Schools. As I indicated earlier, I have been the superintendent since 2009, but have seen a dramatic change within the past 5 years, with each successive year getting progressively worse. Among the first impacts we noticed was that our usually strong elementary attendance began to decline. When I talked with our principals about this a few years ago, they told me that they attributed much of the decline in attendance to parents not getting up and getting their kids to school because of drug use, and how difficult it was to make contact with parents to talk about attendance, achievement, and grades. Also, we have seen a progressive decline in attendance at parent-teacher conferences at the elementary level.

We work hard to provide every child in our county with a high quality pre-school experience in our district. This remains a top priority of our local board of education, and we have two Maryland Judy Centers (pre-school initiative named after Maryland Congressman Stenny Hoyer's late wife). We collaborate with our Special Education Department to identify the special learning needs of our children as early as possible through our Infants and Toddlers program. In doing this work, I can tell you that we have experienced a sharp increase in the number and percentage of our children who require special services due to the opioid crisis. Our local health department shared that this year 18% of all newborns in Allegany County are born drug affected, and this statistic does not include those children who may have been exposed to alcohol during their pre-natal development. That is one in 5 of all children born here.

Last school year, we experienced several occasions where parents overdosed and died in their homes while their young children were present. On two different occasions, staff from our County's Head Start Program made home visits only to encounter a young child who answered the door. Each of those times when asked "Where is your mommy?" the child responded, "She is asleep", and when further investigated, the mothers were deceased. In both cases, the cause of their death was overdose.

On another sad occasion last school year, we had a Kindergarten student who came to school on a Monday morning after staying with her father over the weekend. When she got to school, she was sick and had a fever. The School nurse tried to contact the mother, since the custody schedule indicated that the mother was the Monday care giver. When the mother did not answer her phone, the school's secondary emergency contact was a grandfather and he was reached to come to pick up the little girl to take her for medical attention.

Unbeknownst to anyone else that day, the little girl's mother and her boyfriend had overdosed in the mother's home, at which time the boyfriend's 5 year old son, who attended another elementary school, was also in the home. When the boy ran out of food that he could readily eat, he went to neighbors' houses and knocked on doors to ask for food, and this led to the investigation and the discovery that the little girl's mother and her boyfriend were dead from an overdose of Fentanyl. It was estimated by the authorities that the mother and boyfriend had been dead for about 2 days. If the little girl had not been sick at school on Monday, or if the boyfriend's son had not sought food from neighbors, the little 5 year old girl would have gone to her mother's home on the bus and would have encountered the dead bodies of her mother and the mother's boyfriend.

Imagine, if you will, the long term impacts of these two innocent children who have become victims of this crisis.

Also last year, a Kindergarten student was attempting to ride his tiny bicycle to school on a busy street in Cumberland after having missed his bus. A Good Samaritan woman stopped her vehicle and took him and his bicycle to his school just before he would have crossed 4 lanes of traffic on Industrial Boulevard in Cumberland. The mother of this child had not overdosed, but was drug affected to the point that the child could not awaken her to take him to school after he missed the bus. When the school finally did get to speak with the mother, she was unaware as to where her child was.

I, or many of my superintendent colleagues, could provide more accounts of similar instances, but I think this provides you with an idea of how devastating this crisis is to too many of my children in Allegany County Public Schools. Imagine the long term mental health implications of these situations, and also imagine insufficient resources to deal with the mental health needs of my children and their families.

My elementary principals have reported to me that they are experiencing more children who have severe behavioral issues as they enter school. We have, in fact, some pre-school and Kindergarten students who require full time adult support just to manage their behavioral issues as they work on individual behavior plans; and much of the time, there is limited parental support.

The good news is that for many of our children, their public school is the place that they are the most loved, best cared for, where they receive the best nutrition, and are the warmest. Just like the little boy who was trying to ride his bike to school with all the dangers of traffic unknown to him, he knew that his school was a place where he would be taken care of. His principal described him as a “rounder,” but also as a sweet child who had many, many needs. I am proud of his principal, his teachers, and his school for being a safe place for him, but I know that he has many more needs that go beyond the resources available.

III. Community/State and State Efforts Underway to Educate Citizens

Our county sheriff has hosted a series of town hall meetings for the community for the past 2 years and is beginning a new series this week. Our county partners have collaborated in many efforts to educate the larger community. A partial list of the community efforts include:

- The Greater Cumberland Committee Education Subgroup
- The Opioid and Heroin Prevention Taskforce
- The Opioid and Heroin Fatality Review Board
- The Drug and Alcohol Abuse Council
- The Western Maryland Health System Opioid Summit and its policy subcommittee

Allegany County Public Schools has revised its Health Curriculum to include specific information for students for substance abuse at all grade levels, but is particularly focused at the high school level on prevention of the use of opioids. We have two recovering opioid addicts who give presentations to students in high school health classes, as a part of their curricular experience.

Maryland has been a leader on this issue through the General Assembly and the Maryland Department of Education (MSDE). This year, MSDE has developed and shared the “Heroin and Opioid Awareness and Prevention Toolkit” as a resource guide for schools. As well the General Assembly, during the 2017 session passed the Heroin and Opioid Education and Community Action Act of 2017 (Senate Bill 1060).

All schools have stock of Naloxone (Narcan) and staff members who can administer the opioid antidote to persons who are believed to have overdosed.

Our Lieutenant Governor, Boyd Rutherford, asked to meet with all of Maryland's 24 Superintendents earlier this year to discuss this epidemic. He attended a meeting of the Public School Superintendents Association of Maryland (PSSAM) and listened attentively to the concerns of Maryland Superintendents representing the nearly one million public school students in the state, and he also discussed Governor Hogan's commitment to work on this issue, and to provide additional funding to local school districts.

IV. Challenges that are yet unmet with effective solutions

As indicated earlier in my testimony, this crisis has challenged our public schools and has stretched our staff and financial resources well beyond anyone's expectations. I do appreciate that President Trump has recently recognized this as a national crisis, just as has Governor Hogan. It is my hope and plea that our Federal Government will allow flexibility of the use of Federal Funds to allow local school districts to utilize resources to help with our efforts to combat this crisis and attend to the many unmet needs of our children. There is a good opportunity that Title IV funds in the new ESSA regulations could provide some additional flexibility to school districts.

I have great difficulty in finding the words to describe the magnitude of the unmet mental health needs of my students and families. The opioid crisis is connected to this issue on the front end, in that many are self-medicating their depression and anxiety, and many come from families with histories of addiction issues. Children are left with mental health scars when they lose parents to overdose deaths, and quite simply, there aren't enough resources to provide all the needs for counseling, therapy, and treatment. Keeping options for Children's Health Insurance Programs is a critical need.

We also need help to quell the supply of illegal drugs including opioids into this country, and particularly Fentanyl. There are yet too many physicians who over prescribe opioids, and in my inquiries, I have not been able to understand who holds those accountable who are sworn to "first cause no harm," when some physicians knowingly keep those addicted in supply of prescribed opioids.

V. Expression of Appreciation for the opportunity to share

I want to express my most sincere appreciation for this opportunity to share this information and perspective to this committee. Thank you for the work you do for all of America's Public School children each and every day. My kids count on you, just like they count on me. If there is anything that I can do or that AASA can do to provide additional perspectives or information, please contact us.

Chairman ROKITA. Thank you, Dr. Cox. I appreciate all the witnesses' testimony.

I would like to recognize the chairwoman of the full committee, Dr. Foxx, for 5 minutes.

Chairwoman FOXX. Thank you, Mr. Chairman, and thank you for convening this hearing. It is a very, very painful topic to be talking about, but it is one that I know we need to discuss.

Mr. Robinson, in your testimony you talked about workforce preparedness and helping to educate people. How does preparing and educating individuals to reenter the workforce increase their motivation for treatment?

Mr. ROBINSON. Vocational education is a part of a continuum of care for addiction treatment. It drives greater levels of success for really three reasons. One, when someone enters treatment and knows there is a second chance career path it inspires hope and increases treatment motivation. Number two, the twelfth of AA informs us that sharing our recovery is one of the foundations of long-term sobriety. So this concept suggests that finding purpose in helping others strengthens your own recovery. And then, finally, and I think most importantly, experiencing the dignity of work gives recovering addicts who have reentered the workforce a positive self-image, confidence, and helps them to establish career goals and a plan for their future.

A great example of this is Vanessa Keeton, who was an IV heroin needle user who entered one of our residential treatment centers and completed our internship program. She later became a treatment center director while earning a college degree and purchasing her first home. And recently she resigned as our HR director and now started a business that is supporting her family.

Chairwoman FOXX. Thank you very much. And thank you, particularly, for mentioning the dignity of work. I don't think we do that often enough in our conversations.

Ms. Miner, you discuss how families need to be part of their own solution. Can you elaborate on what this means? And my assumption is it is different for different families, but you might want to give examples of that.

Ms. MINER. Absolutely. Families are different, they are unique in their own ways. Really, in my position in Colorado, I sit down with the families and discuss with them what it looked like for them when things were going well for them, before their addiction had taken its toll, what their children looked like, what kind of supports they had in their family. Because all too often we find that when someone is in active addiction that they have really severed their ties with all of their good supports in their life. And they really believe that this is severed for life. I share my story with them and tell them about how bad I had hurt my own mother through my addiction and she is now my best friend again and my biggest support. And really we have got to get these families to believe that they have the power within themselves to do it.

Chairwoman FOXX. Thank you very much. Dr. Cox, I represent Alleghany County in North Carolina but we spell it just slightly differently, we put an "H" in it there. And our county is not as large as yours and I don't think it has quite the same problems, but I love representing Alleghany County in North Carolina.

You discussed the need for flexibility for the use of Federal funds to allow schools districts to utilize available resources to help meet the needs of the students. How would additional ESSA Title IV fund flexibility help you as you respond to this problem?

Dr. COX. Well, let me give you a very specific example. And I go back to a meeting I was in yesterday with my elementary principals. It was our regularly scheduled time and we talked about some of these issues and the presentation of kids with lots of needs. In our district we have one behavioral specialist that serves the needs for all of my 13 elementary schools. While I am grateful that we have the Title IV funds, you basically have to write your plan to fulfill three different areas. And in our county we get \$70,000. And it would be helpful if I could pool all of that money to be able to hire another behavior specialist to help with my elementary principals and the counselors and the nurses in the school to design plans to deal with the behavioral issues. I mean, that is one example.

And I think, you know, in all of our public schools in Maryland, across the country, having greater flexibility within the Federal entitlement programs to meet the specific needs in each of our jurisdictions would be very helpful to all of us.

Chairwoman FOXX. Thank you. And thanks to the panelists, again, and thank you, Mr. Chairman, for indulging me. I yield back.

Chairman ROKITA. I thank the chairlady. I recognize Ranking Member Scott for 5 minutes.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman. Mr. Chairman, it seems to be a consensus that we should treat the opioid addiction through a public health strategy rather than a criminal justice strategy, which means primary prevention before people get in trouble and then responding afterwards.

Dr. Wen, you mentioned in your closing statement a need to support early intervention for women, infants, and children. What does that mean and what can be achieved?

Dr. WEN. Thank you for that question. We need to have early intervention and detection. That would include things like home visiting services, which have been found to have profound long-term effects on improving children's health and also the health and wellbeing of their families, too. We know that there is a cycle that exists, this cycle of poverty, trauma, addiction, that addiction often begets addiction. And we need to do everything we can to break that cycle, to have early intervention where possible, to have prevention services, but also critically, when people are seeking treatment we need to be there for them. We should not have to tell them to wait weeks or months, but we should make every interaction the opportunity for intervention.

Mr. SCOTT. Well, if you are going to have a public health response as a cost after they get addicted, to paying for the services, can you repeat what you said about the effect of cuts in Medicaid and removal of behavioral health coverage as an essential benefit in health policies?

Dr. WEN. Absolutely. In Maryland alone there are 250,000 people who gained insurance because of expanded Medicaid. All these individuals could stand to be without access to treatment if Medicaid

were cut. Essential health benefits, too. One out of every three individuals who now are newly insured through ACA plans might not have gotten coverage before because essential health benefits did not include addiction services. For all these individuals there is no margin of error. So an individual who is in treatment now, if they don't have treatment tomorrow their only option may be to overdose and die. And at a time of a public health epidemic the last thing that we can afford to do is to deprive people of the coverage they have instead of providing access to treatment for the more than 1 in 10 who cannot access it now.

Mr. SCOTT. You made a comment about dealing with the supply. Can you say why investments in cutting supply are inherently unsuccessful?

Dr. WEN. Well, currently substance abuse already costs society \$600 billion annually in medical costs and incarceration costs. So we need to invest much earlier. And cutting supply alone is not going to work unless we also address demand, because currently we have millions of people who have the disease of addiction. If we are not able to get them treatment, that demand is going to continue to fuel supply and that is why a public health approach combined with a law enforcement approach are what we need. That is the humane thing to do, the ethical thing to do, and it saves society money.

Mr. SCOTT. Thank you. Dr. Cox, you indicated that superintendents need flexibility with the funding. Isn't it true that superintendents have also been asking for significant increases in funding, particularly Title II-A funding, and other funding that can help address this? Not just flexibility, but more resources?

Dr. COX. We have a lot of needs and certainly additional funding would be helpful. One of the greatest needs is that for treatment, that we have children whose mental health needs are not being attended to because there aren't enough resources to do that.

Mr. SCOTT. And so you need more resources, not just flexibility?

Dr. COX. Yes.

Mr. SCOTT. Thank you. And, Mr. Chairman, I yield back.

Chairman ROKITA. I thank the ranking member. I recognize myself for 5 minutes. I thank the witnesses again.

Mr. Robinson, you mentioned Alcoholics Anonymous, and pardon my ignorance, does it receive Federal funding?

Mr. ROBINSON. No, it does not.

Chairman ROKITA. So that allows you to explore the spiritual element of the recovery process?

Mr. ROBINSON. Yes, absolutely. And, again, you know, in our treatment centers we still have an addictionologist leading our medical programs. We are nationally accredited by CARF, so we are recognized as a center for clinical excellence.

But we have added two things to our programs that maybe not all programs have, and one is a spirituality program, which is very, very important, especially when you start looking at pastoral care and chaplains. And that is very consistent with other faith-based health systems that we have across the country.

And then, finally, as I said in my comments, we have added vocational workforce development as a key part. And so you really have to treat the whole person and spirituality is a piece of that.

Chairman ROKITA. And funding source aside, and regardless of it, you recommend spirituality and vocational for every program?

Mr. ROBINSON. Absolutely. I think we should be investing in programs that are holistic, that are treating the whole person. Addiction devastates every aspect of someone's life.

Chairman ROKITA. Thank you, Mr. Robinson. And then you mentioned Medicaid-eligible healthcare providers. Can you unpack that a little bit?

Mr. ROBINSON. Yes. I mentioned the peer support specialists in our State is a Medicaid billable professional, which is incredible public policy because it creates employment for people recovering from addiction. And it puts them to work in a field that is the best thing for them to do, which is to share their recovery with other people. And so in our State, for some billing codes, a peer support specialist, who is someone who has been clean and sober for a year, that has either got a high school diploma or GED, that goes through a 40-hour course, they become a behavioral health practitioner. And organizations like ours hire those individuals to lead group, to do individuals, to go to needle exchanges, to go to ERs—

Chairman ROKITA. And what is the cost to get them trained—or educated, excuse me, so that they are Medicaid billing eligible? Roughly.

Mr. ROBINSON. So it is a 40-hour cost and our academy has added lots of other skills. Our Workforce Development Board provides us approximately about \$10,000 for each one that we train. But we are training super peer support specialists that are certified in CPR, first aid.

And one of the other things about peer support specialists is it prepares them—when they start getting this medical training they can go into other careers other than peer support, enter the nursing field or other healthcare professions, like medical assistants.

Chairman ROKITA. Thank you, Mr. Robinson. Let me skip over to Dr Cox here. You mentioned, I believe, if not in your oral testimony, your written testimony, community task forces?

Dr. COX. Yes.

Chairman ROKITA. Can you unpack that a little bit?

Dr. COX. Sure. We have several—

Chairman ROKITA. How do you organize them? Who is involved? What is the cost associated with it? What is your funding source if there is a cost to the county?

Dr. COX. We have several actually. The Western Maryland Health System sponsors one and they are called actually The Summit. And they are the recipient of some State grant funding.

Chairman ROKITA. Summit?

Dr. COX. The Summit, right.

Chairman ROKITA. Okay.

Dr. COX. I am a member of the Greater Cumberland Committee Education Workforce. They also had an EVANA forum. And then we have staff members who participate in various committees with the health department. We have a lot of efforts underway. Our sheriff, as a matter of fact, this evening will kick off another series of town hall meetings all over the county. So we have done a really good effort of educating the population about what addiction is.

Chairman ROKITA. What is the effect so far? Can you tell?

Dr. COX. Well, I think we are a lot better educated as a community about the aspects. I mean, for example, just educating people who have no experience with addiction, that people use to feel normal. That is one of the hardest things I think for people to understand is that a person doesn't use necessarily to get high, but just to feel normal so that they can carry on and function. So that is one of the things that we have—

Chairman ROKITA. Thank you. Thank you, Dr Cox. Coming back to Ms. Miner now. You indicated in your testimony—and thank you for sharing your tragic story as well. I appreciate the courage that must take. You mentioned that you thought you weren't affecting your kids, perhaps they didn't even know, and then obviously you say you now have children that are or were drug addicts. So they did see your behavior? What do you think the cause is? Is it just more than observation? Or what is your instinct as a mother there?

Ms. MINER. They did see. They saw that I was not present. They saw that when they needed me to wake up in the morning to take them to school that I could not do it. They saw that when they were clinging on my leg wanting mommy time that I could not be present because—

Chairman ROKITA. Why does that make them become a drug addict in your mind?

Ms. MINER. You know, I really believe—and after talking to both of my daughters, that because they witnessed so much tragedy in their life and because there was so much trauma that was never dealt with them. When I first got clean everyone swooped around me because I was pregnant with my son, but nobody helped my daughters who had suffered significant trauma. And trauma is a leading cause to substance abuse.

Chairman ROKITA. Thank you. At the risk of breaking my own rules I need to stop. I apologize. Thank you very much for your responses.

I now recognize the ranking member of the K-12 Subcommittee, Mr. Polis, for 5 minutes.

Mr. POLIS. Mr. Robinson, can you confirm if your centers accept Medicaid and receive Medicaid reimbursement for services?

Mr. ROBINSON. We do.

Mr. POLIS. Okay. I just wanted to be clear to point that out as a Federal funding stream.

Ms. Miner, you know, I think the power of your personal narrative is very strong. Do you have any suggestions about what we can do either officially as a committee or unofficially as individuals to encourage more people like yourself to be open and share their own stories and narratives and help educate others?

Ms. MINER. I really believe that people like myself can help to build the power of people in recovery up to want to come and talk. It is a very frightening thing to go out and share your story because you never know the reaction that you are going to get from people. We are our own worst critics and we tend to think that everybody that we go and talk to is just going to look down on us. It is really about educating us and really helping us to get our voices out there and for you to really want to listen, and for us to know that you want to hear what we have to say.

Mr. POLIS. And, you know, I have also appreciated the movement that many families who have lost children or family members to the opioid epidemic have been more forthcoming in their obituaries to mention the true cause rather than sweep it under the rug. The more visibility and awareness I think the more empowered we are to counter this deadly epidemic.

Dr. Cox, I want to thank you for being here today and sharing some data about the opioid crisis. In your testimony you talked about the funding struggles that your district is facing. In Colorado, when I meet with superintendents and school board members, often funding is one of the first issues they bring up. Still, school districts are being asked to do more with less. And we have never met through this body our full commitment to special education funding.

Most recently there is significant scale-backs in funding for ESSA. For instance, eliminating Title II has been proposed and cutbacks in Title IV Part A. Can you share the importance of fully funding Federal education programs, specifically Title IV, and how this could benefit Allegany County Public Schools in your efforts to support students and families impacted by the opioid epidemic?

Dr. COX. Sure. You are correct. I mean, we have so many needs and this opioid crisis has only contributed to that. And we are funded by a combination—and every State is a little bit different, but most of our funds come from the State of Maryland. Second is going to be our local county government, and then the third pool is the Federal funds. So we use a combination of all those funding sources to meet the needs. And, as you mentioned, with IDEA not being fully funded it really imposes some hardships. And this issue impacts the IDEA needs that children have. So it is only going to create more need for children. So, you know, whether it is additional funding for IDEA or Title IV flexibilities or additional Title IV funds, we just need more resources to deal with the issues.

Mr. POLIS. And, Dr. Wen, I want to thank you for being here this morning. I am fortunate to represent a district with several research universities, University of Colorado at Boulder and Colorado State University, both of which are leading research universities doing great work to help better understand the opioid epidemic. In a recent study from CU in partnership with the VA in Colorado they found that patients almost universally cited emotional support from family members and healthcare providers as essential to recovery.

Can you speak to the emotional support for family members and healthcare providers, and specifically what Baltimore is doing to help provide emotional support services for patients?

Dr. WEN. It is critical to remember that when people are recovering from the disease of addiction they need not only the medication assistive treatment, which is also the gold standard, they also need psychosocial counseling and wraparound service, social services. And also that people who are addicted to opioids are not only treating physical pain, they are potentially treating some other type of pain as well that might include emotional pain and trauma.

And so in Baltimore, we provide services for healthcare workers. We provide services also to assist with our most vulnerable, including our children in our schools.

Mr. POLIS. And are those models—do you think they can be expanded or scaled, included in rural areas?

Dr. WEN. Absolutely. We have many evidence-based pilots and evidence-based programs in Baltimore. We know what works. We just need the resources to scale them up in our jurisdiction and across the country.

Mr. POLIS. And I will finally go back to Ms. Miner. Can you share a little bit about your personal experience as an advocate working across different systems and different jurisdictions that are all trying to work on this issue and how you have been able to try to bring people together through your own personal narrative and advocacy?

Ms. MINER. Absolutely. We are still very siloed, I am finding out, across the country, but I am finding more and more, at least in Colorado, that people are wanting to work together. They are wanting to talk so that we can help eliminate the trauma to the family from the family having to tell their story over and over again because every time they have to repeat it is more traumatizing to them and to their children. And with me working so closely with the executives that we have in Jefferson County, it makes it that much easier for me to help them partner with each other and with the families. And they really want to listen to what the families have to say.

Mr. POLIS. Thank you. And I yield back.

Chairman ROKITA. The gentleman's time has expired; the gentleman yields back. Chairman from Kentucky is recognized for 5 minutes.

Chairman GUTHRIE. Thank you very much. It is great to be here. And I just want to say that this is something that is not going to be solved solely in Washington. Certainly you guys are on the front line at the local level. I just want to point out for the witness testimony earlier, joining us was Kim Ozer from northern Kentucky, which is not just the north part of our State, northern Kentucky is how we define our Cincinnati suburbs. So if you live in northern Kentucky, you are closer to a Reds game than if you live in north Cincinnati.

And though hearing opioids has been statewide, we call the I-74 corridor in Appalachia, where you are, has been really the brunt of it and all the work moving forward. And there are so many issues and there are so many committees here looking at this crisis together. But on the Higher Ed Committee that I chair, we are really looking at how the opioid crisis is affecting the workforce.

So I did my 21 town halls in August. Everywhere I went most were talking about healthcare, but there was not one that people were not talking about the heroin problem and opioid. They say heroin back home, but we are talking opioids in general. And so it is everybody who is focused on it want to move forward, but every employer that I would talk to who were looking at—I think every employer I talked to in Kentucky—you will probably find some rural areas, but probably in your area that is not—are looking for people to hire and the biggest problem they are seeing is passing the drug test, a lot of people who show up to work. So there are a lot of issues that we just can't look at the criminal justice problem, we have got to look at it holistically. I don't want to dismiss

that part of it. I have changed my attitude on that, too, is that we have got to look at people are in trouble because they are addicts, not the other way around.

So the big thing is, as you said, I think you hit it, the dignity to get them to work. And I know your program does that. And so what are you hearing from local businesses? And I know that you tailor some of your programs from what local businesses have told you they need to get certificate programs. Could you address that? Mr. Robinson? I am sorry, I am talking to you.

Mr. ROBINSON. Our first training was to provide peer support specialists for the addiction treatment field. And those folks are going to work not only for us, but for other providers, community mental health centers, hospitals, health departments.

One of the things that has recently happened to us is we had an executive with a major industrial maintenance company approach me. I was actually just eating in a restaurant in our town and he said we are needing to hire people. We can't get enough folks to pass the drug screen, and especially we need welders. So we are right now in the process of adding a welding program to what we are already doing and that is going to allow us to create a flow not only of an opportunity to allow someone that is recovering from addiction to maybe start a job at \$40,000 or \$50,000 a year, but it is going to provide a flow of employees who are in some ways kind of drug-proof because they have been through treatment, they have got the support.

And, again, that dignity of work, the confidence that comes. One of the most compelling stories I heard was one of our graduates came by my office, it was such a big deal, to tell me that he had just been to the social services office and told the worker there to take his kids of Medicaid because he had private health insurance. And that worker said it is the first time they had ever seen that. But I could see in his eyes just tears welling up when he was able to come and share that with me and came to my office to tell me that.

Chairman GUTHRIE. That is great. And I know Sullivan University out of Louisville is partnering with you so people can also earn credentials, academic credentials, with your training program. How does that work?

Mr. ROBINSON. Sullivan has been a great partner. And they are just one of our most outstanding private universities in the State, including having a pharmacy school. And so they just came along and said, look, we have got a responsibility as an education provider to be involved in this issue in our State. And they came to us and said how can we be involved? And so they stepped forward, and at their own cost are awarding college credit for our peer support academy. Those folks are not having to pay any tuition dollars. They are awarding equivalency credit, which is fantastic.

And now we have got other educational groups, like our community college system, who is coming to us and saying we want to do the same thing Sullivan is doing. And, again, this idea of putting vocational workforce skill-building as a part of the treatment continuum, we have never seen anything increase the outcomes of our treatment programs better than this.

And, like I said, the first graduating class of our peer support specialist academy we graduated 16; 14 of them today are full-time employed, they are sober, and they are 18 months at least clean and sober, so that is 85 percent. That is an incredible return. And I think we can do that in all kinds of different professions.

Chairman GUTHRIE. Well, thank you. I appreciate that very much. And I don't have enough time to ask another question, but I was going to ask Ms. Miner just about working with families. But I just want to say when you guys share your stories that has got to be extremely difficult to do and put your family out here as you have already done earlier today. But it means a lot. I think it adds to what we are trying to do and it certainly encourages other people and I appreciate you doing that, all of you who shared your personal stories and the work you do.

And my time has expired. I yield back.

Chairman ROKITA. The gentleman yields back. Ranking Member Davis recognized for 5 minutes.

Ms. DAVIS. Thank you so much, Mr. Chairman. And for the record, I wanted to put in this State Health Reform Assistance Network article, "Medicaid States: The Most Powerful Tool to Combat the Opioid Crisis." If I can put that for the record.

Chairman ROKITA. Without objection.

Ms. DAVIS. Thank you very much. You know, I don't think any of us could sit here with your very compelling testimony and not be moved, not be concerned, and on some levels a little outraged as well that we are not finding our way to provide the resources that are needed to spot—you know, with all the compelling good work that is being done in our local communities. Because I think the local communities are the foundation of how we respond. But we can't do that if we don't have the resources. And so it is very important. We are doing that in the context of contemplating trillions of dollars' worth of debt that we are taking on right now, knowing that as the years go by into 2025, 2026, the families who could be hurt the most are those today that are really the most vulnerable when it comes to the use of Medicaid and health and support that is out there.

So, you know, I can't help but say that because I think that we have to put this in some context. And it is wonderful to have the sympathy, the empathy, the drive to change things, but it is not going to happen if we don't recognize that we are making choices every day here in the Congress. And the choices that we are making today, unfortunately, I don't think are in line with what we see as an emergency in our country.

And thank you very much for your being here because you represent really the issue that we are facing today.

It was interesting to me, Mr. Robinson, as you were speaking I could not help, but think of some of the issues that we look at when it comes to the transition of our military into civilian workforces. And some of the issues and the need that we have had to have companies acknowledge and know more about what they are bringing to the job, all the wonderful benefits they bring in terms of knowing how to conduct themselves at work, but also some of the trauma, in fact, that has been experienced. I wonder whether you see that there is a link, some relevance to that, and

whether or not we could be looking at some of those models as well? Does that align for you?

Mr. ROBINSON. Yes. As a grandson of a World War II veteran this is something that is near and dear to my heart. I still remember my grandpa wearing his DAV hat. And so he taught us to take care of our military, whatever we can do.

So we have had several veterans come to us for treatment because there still is a lack of access for those that are coming back.

And one of the big success stories, one of the favorite stories I love to tell, is Brandon Leslie, who was an Afghanistan and Iraq veteran that came to us. He was an IV needle user suffering from PTSD, went through our program, did our internship program, became a residential staff, then a center director, and now he is the assistant director over nine residential centers, and he has only been clean and sober for 3 years. And so one of the things that I noticed were his leadership skills that were just inherent in who he is that he learned in the military.

And so we need more of our veterans that are struggling active duty to get into recovery because he can talk to them in a different way than anybody else can.

Ms. DAVIS. Mm-hmm. And I think that goes for Ms. Miner as well. I mean, as someone who has been clean, as you noted, for many years, you have that special gift to be able to communicate that as well.

Dr. Wen, so within these discussions I think it is clear that there needs to be a Federal response with the help of our local communities. Can you say why is that important? Why can't all of this just happen if communities did the right thing?

Dr. WEN. We are already doing what we can with extremely limited resources, but I will give you an example. Because we are out of money for Narcan, if we were to get money to purchase 10,000 units of Narcan today I can distribute all 10,000 units by the weekend. Think about how many more thousands of lives we would be able to save every day in our local communities if we had the resources and the will to do so.

The opioid epidemic is a solvable problem. This is what frustrates me every day. We know what works, we know the science is there, we just have to do the right things, including protecting existing insurance coverage, but also expanding coverage and increasing the resources to allow us to do what we already know based on evidence works.

Ms. DAVIS. Thank you. Thank you, Mr. Chairman.

Chairman ROKITA. Thank the gentlelady. Congressman Allen, you are recognized for 5 minutes.

Mr. ALLEN. Thank you, Mr. Chairman. Appreciate you all coming and sharing with us about this difficult, really difficult problem that we have.

In this country it really dates back to the 10th century if you read about the problems in China. I do not know how many male citizens of the United States are on drugs, but in China in the late 1800s over 25 percent of the male citizens of that country were opioid users. And, of course, they went to great lengths to deal with it there.

You know, when I am out and talking with educators, it is difficult because a lot of our educators tell me their biggest challenge, not only in elementary schools but also in colleges, is emotional health of the student body. And, you know, I look at my days in college and I thought that was a great time to be—you know, I had a great time in college, it was a wonderful experience. So I don't know what has happened since I was in college. I know that I was fortunate in that drugs really did not come on the scene until I was out of college, at least at my particular college. But I saw it as soon as I got home after college with a lot of my friends who I went to high school with that became drug users.

I will tell you this, we have got 6-1/2 million jobs open in this country right now. I did a 19 county tour in August and I met with our chambers and our county commissioners and our mayors, and economic activity is at its highest level. I met with a company that is going to add 100 jobs in one county. They had 400 applicants and only 40 could pass the drug test. Folks, we have got a serious, serious problem.

I talked to law enforcement. In most of my counties my sheriffs say that if we didn't have a drug problem they wouldn't have anybody in prison. And maybe there would be something else going on, I don't know. And a lot of it is people have entirely too much idle time.

And so, you know, with that, Mr. Robinson, obviously treatment is critical, but, you know, somehow—how do we stop the supply? Because, like I said, if you read the history of China when they cut off supply, the price, you know, increased dramatically which stopped a lot of the use. Because right now, as I understand it, opioids are very inexpensive. The street stuff is very inexpensive to get. Do you have any comments on that?

Mr. ROBINSON. I mean, I think we always have to be diligent when it comes to attacking supply. One of the problems that has happened with the prescription drug problem is that it is hard to stop the supply when you have grandmas and people who in their medicine cabinets have a 90-day prescription or a 30-day prescription for oxycodone. And the opiates we looked at, you know, 20 to 25 years ago are nowhere near as potent as it is today. When you take a pill such as an Oxycontin table that has—is supposed to release the morphine, the opiate, over time and then you crush it and it gives you the full potency of that, the addictive nature of that is just so much more than maybe just the heroin that was available in the '50s and '60s.

The other thing is now we are getting these synthetic versions, like carfentanyl and fentanyl, which are 100 and 1,000 more times more potent.

Mr. ALLEN. But again, that is a business decision by the pushers to get more people addicted. I mean, you have got to go to the source here and stop this.

Mr. ROBINSON. Yes, absolutely on the pharmaceutical companies.

Mr. ALLEN. If we get serious we can stop it. I mean, the country I think has got to get serious about stopping this problem. I mean, you can't just say laissez-faire, we are going to prescribe some by-product. Now, obviously we have got to do something with those folks who are on drugs, but until this country decides we are going

to deal with this and we are going to deal with this in a way that we are going to stop it, I don't know how we stop it. I mean, is there any disagreement?

You know, in other words, we have a very, very serious problem here. And, you know, I am hearing, well, treatment and throwing more money at it and this sort of thing, we have got to stop—it is always the money. You know, in China, you know who it was? It was the British that were making all the money off the drugs. And so, you know, I wish you all the luck in the world and I am thankful for what you are doing. Thank you so much for what you are trying to do.

I yield back.

Chairman BRAT. Thank you. I recognize Mr. Courtney for 5 minutes.

Mr. COURTNEY. Thank you, Mr. Chairman. I want to thank the witnesses for your thoughtful testimony today. Again, and the topic of the hearing which is to sort of even get beyond the emergency, you know, first responder healthcare, but the ripple effect that is happening in communities, which is true in New England as well. A couple of weeks ago, I was with the school superintendent up in Enfield, Connecticut, which is a suburban town in Hartford County. It's about 50,000 population which again in 12 days this year they had 13 overdoses, you know, show up at the police and volunteer fire department. But the school superintendent actually pulled out some data which was actually pretty—it was even another layer of alarm because he was describing what they are seeing in kindergarten in the schools where, again, behavior is just totally unprecedented in terms of what teachers and staff are seeing.

So, for example, they have the data, physical assaults in kindergarten in the school year of 2013–2014 were 1 for the whole district, there were 14 in 2016, last year's school year. The emergency protective holds in kindergarten in 2013 were four. There were 114 in 2016. And, again, the kids with emotional disturbance—and I am going to submit this data for the record, Mr. Chairman—but what it is doing to teachers is that—you know, these are veteran kindergarten teachers who are like at the end of the school day in tears because they are just so overwhelmed with kids.

They have a term for some of the kids, they are called runners, where they just literally bolt from the classroom out the building, chasing them in the streets. And so, you know, this has created a challenge that aside from everything else that school superintendents have to deal with in terms of State budgets and local property taxes, about how do you get some, you know, stability under the roof of a school district.

So one of the things we did in this committee with the ESSA, which was a great bipartisan achievement when signed by President Obama, but a lot of the Republican members were there at the White House, that updated the Elementary and Secondary Education Act. We again really bolstered the Title II, Title I, and Title IV funding that directed money to help schools, and teachers in particular, to sort of get trained up to deal with these behavioral health problems, which again didn't really exist even as recent as 4 or 5 years ago.

And, Dr. Cox, I mean you have really talked about this challenge that you are seeing with your staff. The Title II-A funding that came out of this year's budget from the White House and the majority is zero. And, I mean, that is the exact opposite direction we ought to be going right now in terms of what we are seeing because obviously we are talking about kids in kindergarten. I mean, this is just the bow wave. This problem is going to get worse as kids, you know, obviously come in waves, you know, upcoming years as well as what their behavior is going to look like as they go through the other grades in the school system.

So, again, can you describe what you are seeing? I mean, are you seeing teachers who are overwhelmed with trying to deal with behavior problems that again are just unprecedented?

Dr. COX. Absolutely. And, you know, I refer back to my testimony. In meeting with my principals yesterday at our monthly meeting, every time I meet with them and when I visit schools that is what I hear. And just as an example of that I hear stories, today we had this issue, and sometimes kids do run. But the number of very serious discipline issues that kids have just increased. And I will benchmark it in 5 years that I have seen the sharp increase. And we have to hire additional people just to be with the kids. We don't have the funding for that. I mean, we have to take it from somewhere else. And so, I mean, we have higher class sizes than we would like to because you have got to do what you have got to do and we don't have enough resources to do it.

Mr. COURTNEY. Well, what you just said is exactly what Superintendent Drezek in Enfield described, which is that they need social workers, they need help, but they are already running into staffing challenges just in terms of having people in the classroom.

And so, Mr. Chairman, I would like to introduce this data from the town of Enfield for the record. And, again, I want to thank the witnesses for really raising the alarm about the fact that we are just dealing with the beginning of this problem, not the end of it.

Thank you.

Chairman BRAT. Thank you. I will recognize myself for 5 minutes and I will start with Ms. Miner and others can weigh in.

Ms. Miner, do you have any experience or have children in your programs who have experience with recovery high schools and colleges?

Ms. MINER. Not in my experience, no, I do not.

Chairman BRAT. Well, I will fire away and maybe you have recommendations based on your work, and others can weigh in as well.

The President's Commission on Opioids calls for better educating middle school, high school, and college students with the help of trained professionals, such as nurses, counselors, who can assess at-risk kids. As you know, this epidemic does not just affect older working Americans, it is affecting high school and college kids as well. The President's commission also calls for supporting collegiate recovery and changing the culture on campuses, which I think is great. There is a recovery high school in my district called McShin Academy, where they are seeing great success just 1 year into their program.

And so my question is, how can we focus on supporting recovery high schools and colleges where those kids are having great success? And, Ms. Miner, if you want to weigh in based on what you may have heard about them, and others if you want to weigh in as well.

Ms. MINER. Thank you. I really have not heard a lot about them. I mean, it sounds like it would be something amazing because opioid abuse is very prevalent in high schools, in middle schools. I know my middle daughter, when she first got into abusing substances it was prescription pills. And she was in high school and then she had someone come up to her and say, hey, try this heroin. It is going to get you higher, keep you higher for longer, and it is more easily accessible and it is cheaper. And then she went to that.

And we need to educate our kids. It is a must. They have got to know the effects that the drugs are going to have on them, not just that day, but long-term, and to be real with them. I actually go and talk in different schools and I am not going into the schools to tell the kids don't do drugs because drugs are bad. I am real with them and I tell them this is why you should not do the drugs, because you could wind up liking them way too much.

Chairman BRAT. Thank you. Any others want to weigh in on that one? Mr. Robinson?

Mr. ROBINSON. I think one of the reasons that works so well is because addiction is a disease and it requires treatment and requires support. And so for kids in high school who go to a recovery high school, that gives them that support they need, to have a peer support specialist, the counselor. Same thing on the college level. With all the temptations that are on typical college campuses it would be a very hard place for somebody in addiction to go and be successful. And not just in high schools and colleges, but I think what we are doing, in taking vocational workforce development to get people in addiction straight out of treatment and then give them that vocational rehabilitation and then prepare them for a job to go right to work then, to produce people who can just reenter the workforce instead of going back and selling drugs.

Chairman BRAT. Right. Thank you very much. I am going to ask a question for my colleague, Jason Lewis, from Minnesota. And if any of you want to weigh in on this one. Question, it is aimed at Ms. Miner again. Each of you has mentioned the importance of coordinating with other entities and services in the community. As part of the committee's work to reform the Juvenile Justice and Delinquency Prevention Act we specifically included renewed focus on community coordination of services to prevent and address juvenile delinquency through the local delinquency prevention grant program.

Ms. Miner, can you discuss why coordination of services at the community as well as identifying and addressing any gaps in services is critical to success for at-risk youth?

Ms. MINER. I believe that is really addressing the family as a whole, not just the youth. Like we have said before, addiction is a disease and it affects the entire family. So when you are going in and you are working with these youth more times than not what I have seen is that the addiction goes back to the parents, back to

the grandparents. So we are not just dealing with this youth who is now getting in trouble.

Collaboration is a must. We have got to talk to each other so that these families do not slip through the cracks so that we can actually better educate them on how they can help their whole family.

Chairman BRAT. Okay. I would like to recognize Ms. Blunt Rochester for 5 minutes.

Ms. BLUNT ROCHESTER. Thank you, Mr. Chairman. I first want to really thank the panel, Mr. Robinson and Ms. Miner, for your personal stories. You deeply touched me and I want to thank you for that and also for the work that you are doing; Dr. Wen and Dr. Cox for being on the front lines. I am a new member of Congress and so to hear you reminds me again why we are here. So I want to thank you all for that.

A few weeks ago, I had an opportunity to meet with neonatal nurses in the State of Delaware, and we talked about neonatal abstinence syndrome. And I wanted to go back to something in your testimony, Dr. Wen. You said that you—in the testimony you said the number of babies born addicted to drugs has tripled between 1999 and 2013. Can you talk a little bit about the long-term effects of neonatal abstinence syndrome on children in their academic performance? And, also, has there been enough funding or research in these areas to help us understand the effects of NAS on children as they mature? And Dr. Cox, you could also join in on that as well.

Dr. WEN. We are seeing a skyrocketing of the number of babies who are born addicted to opioids. Many of these children, many of these babies end up having severe problems from the very beginning, including seizures and other withdrawal symptoms that could be fatal. And many of them end up having long-term effects as well, including reduced academic performance. Again, emphasizing why it is that we have to intervene as early as possible. And as early as possible means that we need to provide treatment to women, we need to provide treatment to pregnant women, and also to women before they get pregnant, and in general to people because otherwise we are going to be perpetuating the cycle where poverty and trauma and violence and addiction ends up in another generation as well.

And I think this illustrates the necessity of early investment of treatment of early detection and also of reducing stigma. It is critical that we talk about addiction as a disease, as everyone here has been talking about, because there is treatment available, because we know that recovery is possible. And unless we fight that stigma then people are going to continue to have a disease that otherwise would be preventable and treatable.

Ms. BLUNT ROCHESTER. Dr. Cox?

Dr. COX. Sure. Dr. Wen certainly is in a better position to address the medical aspects. And, again, we have about one in five of our children born in our hospital who are drug affected. And so we make an effort to reach out to them, but we are only able to service about 11 percent of those identified because it is voluntary. And some of the things that are reported to me, the lack of executive function that the children have and just creating very difficult issues that gets to the learning, you have to approach that in such different ways and that is one of the things that we struggle with.

Ms. BLUNT ROCHESTER. You know, the reason why I really wanted to focus on that as particularly Ed and Workforce, we are talking about not just high school and college students or those who are older, but we are talking about babies and then middle school, as you mentioned. And so it is sort of the continuum. And I want us to think about how that impacts our workforce, how that impacts the quality of life, healthcare. It is all connected.

I wanted to ask, also, Dr. Wen, is there a national standard of care for screening or treating NAS and how would creating one help improve treatment for newborns?

Dr. WEN. We need to do a lot more when it comes to addressing this issue, including with a national standard. But I want to bring us back to how can we prevent neonatal abstinence syndrome to begin with, which involves early detection for pregnant women that includes increasing our home visiting services so that we are able to bring women into treatment and critically expanding treatment overall so that everyone has access to live saving services.

Ms. BLUNT ROCHESTER. Thank you. Thank you, also, for mentioning home visiting. I think that is one of the most important programs and one that has been in jeopardy of many cuts. And so again, I thank each of the panelists for your testimony and I yield back.

Chairman ROKITA. Thank the gentlelady. The gentleman from Alabama is recognized for 5 minutes.

Mr. BYRNE. Thank you. Dr. Cox, I have a question for you. I am a former State school board member in Alabama and sort of keep up with things. And I have heard, and it is very disturbing to me, that a lot of our young athletes in high schools get injured in practice or in a game, they go to get treatment and their physician prescribes a painkiller, an opioid, for them and they get hooked. And so I am hearing a large number of our young people are hooked on opioids are actually starting out getting a legitimate prescription for pain drugs because of a sports injury, but then it just gets carried away. I mean, either they don't understand what they are on, then they get hooked and they start doing inappropriate things to get more opioids. I don't know if you have had any experience with that, if you have any views of what we can do about that.

Dr. COX. Sure. I think it is not just student athletes, but any time someone presents at an ER or, you know, has a pain issue, part of that according to—well, our western Maryland health system has developed ER protocols and has tried to educate ER physicians about pain management, and that certainly is a problem. We have had students, unfortunately, that have been prescribed opioids and it has become a problem. But it is not limited to just our students. And that is an area that I think is ripe for growth, too. We have in my opinion too many prescriptions being written for opioids.

Mr. BYRNE. I agree with you, it is bigger than athletes, but high schools—athletes are playing on our sports teams, et cetera, so I sort of feel like we have a little extra obligation to be looking out for them. What can we do for with our student athletes?

Dr. COX. Well, I think it is an education effort. Maryland has taken a lead in this. We actually have legislation that was passed this year that addressed education efforts in high schools. And we

have—this is actually a copy of the opioid awareness and prevention kit. So it is a good resource from the Maryland State Department of Education. It is a part of our health curriculum where we teach our children, you know, the dangers of taking opioids when they are not absolutely necessary.

So I think it is a two part. I think it is educating physicians and folks as they present in ER plus educating our kids through our curriculum and efforts to let them know ahead of time the dangers, that when you take substances like these they can be addictive. So we are addressing that way.

Mr. BYRNE. Dr. Wen, you know, when young people, whether student athletes or not, when they come to an emergency room or come to a physician with a problem, they are young people, they don't necessarily have the same judgment as an adult does and they don't necessarily have the same knowledge of what an adult does. What extra do we need to be doing working with young people to help them understand, hey, this painkiller is not for you to take forever? And you need to be careful that you find yourself becoming too used to it and wanting to have it all the time, describing to them. What is the obligation of the medical profession with regard to this?

Dr. WEN. We know that there is an overprescribing of opioids that is fueling this epidemic. And the CDC has put out excellent guidelines for urging more careful prescribing and we in Baltimore have been working with all of our doctors to ensure that those guidelines are followed. Doctors also need better tools as well. If opioids are the only tools that we have for pain management, that is what we end up turning to. But actually there are many other alternatives that we need to be exploring. But I think you bring up a very important point about what we do for young people because we know that what works for children is not just teaching about saying no, we also have to ensure that young people's lives are not ones that they want to escape from. And that is why the early investment and nutrition and family literacy and housing, all of these other services are critical as well to prevent drug use.

Mr. BYRNE. Now, I will just make this observation, and this is not in any way an indictment of the medical profession, but we come to you, we the nonmedical profession public come to you when we have a health problem. We put ourselves in your hands. Parents, we put our children in your hands. We have an injured young person, you know that they are going to have a lot of pain from whatever you are doing, you are using your professional judgment as to what they should be taking to deal with that pain. Maybe there is also an obligation on behalf of the medical profession to spend a little more time with the family and the young person saying, now wait a minute, this is a very serious pain pill you are taking here. This is not something for you to take lightly. Let us go over what you should be doing and not doing with it.

So I just offer that observation, not in any way as an indictment of your profession. But I think if we all work together I think we can do something about this epidemic.

With that, I yield back, Mr. Chairman.

Chairman ROKITA. The gentleman yields back. Ms. Adams, you are recognized for 5 minutes.

Ms. ADAMS. Thank you, Mr. Chairman. And thank you all very much for being here and for your testimony today. Mr. Chairman, I want to enter into the record if we can a Time'smagazine article regarding the President's desire to stop the opioid crisis and the actions that don't match.

Chairman ROKITA. Without objection.

Ms. ADAMS. Thank you very much. Let me direct this first question to Dr. Wen. Do home visiting services like Head Start and other early learning programs make an impact on the outcomes for children in difficult situations? For example, when a child suffers from trauma due to a parent's struggle?

Dr. WEN. Home visiting programs make a profound difference in children's lives and in the future of their families. Home visiting, for example, has been shown to reduce infant mortality, to improve health for children. Home visitors might, for example, find that there is paint that is peeling, that there may be lead poisoning hazards in the home. Home visiting also has been shown to increase educational outcomes for that child as well as for the mother.

There can also be detection of other issues that come up during home visiting, for example, on domestic violence, on smoking in homes, on other traumatic instances for which there are interventions that are possible. For home visiting to be effective it must be fully funded. And not only is home visiting itself important, care coordination is important, too, because we also have to identify those families that are at greatest risk in order for the home visiting to even occur in the first place.

Ms. ADAMS. Thank you. Are there other ways and opportunities to leverage early learning and early supports to respond to the opioid crisis?

Dr. WEN. We need to be doing everything we can to invest in our children in support for their family, recognizing that things like housing are part of healthcare. Food and nutritional support are critical to education and to health. And recognizing this life course approach is important, too. If a child is experiencing trauma because of substance addiction in their families, what we have to do is to treat their families and make sure that treatment is available at the time that people are requesting. It just is not appropriate that only 1 in 10 people who have the disease of addiction are able to get treatment. We have to invest in treatment now because that is also key to preventing the cycle of addiction from fostering.

Ms. ADAMS. Thank you. Dr. Cox, the School Superintendents Association, along with the Save Medicaid in Schools Coalition, expressed a concern about how the American Health Care Act, also known as the Trumpcare bill, would jeopardize healthcare for the Nation's most vulnerable children. And the coalition sent a letter urging Congress to avert the harmful and unnecessary impacts that AHCA would impose on Medicaid.

So can you discuss the role of Medicaid in providing the school-based health services in your county? And are you concerned about efforts to cut Medicaid there?

Dr. COX. Sure. In my district alone part of our funding structure is we get about \$2.5 million a year in reimbursables for the medical services that are delivered to our children while at school to meet their learning needs, and a lot of that is through their IEPs. We

have children that are medically fragile, all kinds of different things. And AASA has taken a position on that as well. I would just reference that about 50 percent of my children in my district do qualify for services for the children's insurance healthcare, or CHIP. And so we are concerned about that as well.

Ms. ADAMS. Thank you very much. Ms. Miner, thank you for being here, thank you for sharing your story. And I appreciate your comments on focusing on the whole family, which is the approach that we need to take to address this addiction. We have the jurisdiction over programs in this committee that serve pregnant mothers all the way to programs that serve the elderly. So we have that opportunity right here in our committee to address those things.

Can you discuss why this holistic approach is absolutely needed?

Ms. MINER. Sure. Addiction is a family disease. It does not just affect the addict. We have got to serve the entire family. We have got to go in and we have got to educate teen moms, we have got to educate them when they are young. I have conversations with my teenager and with my 8-year-old that are in my home all the time about drugs and alcohol and cigarettes and why they should not use them. And they carry this with them. They go into school and they talk about it. They have deep discussions with their peers at school. They go out in the community and talk about it as well. It is really about prevention and intervention with the families.

Ms. ADAMS. Thank you very much. And, Mr. Chair, I yield back. I am out of time.

Chairman ROKITA. I thank the gentlelady. Mr. Mitchell, you are recognized. No, no, no, Ms. Stefanik, you are recognized for 5 minutes. Excuse me.

Ms. STEFANIK. Thank you, Mr. Chairman, and thank you to the committee for having this hearing today to highlight such an important issue. As we know, the opioid epidemic has wreaked havoc across this Nation. I represent the North Country, which is a district in upstate New York, and we have seen an exponential increase in deaths related to the heroin opioid crisis. And many of my local law enforcement, many of my counties, many local advocacy groups have come together to really foster these types of conversations in the local communities.

My question, and I want to direct it to Ms. Miner to start with, I have met with so many families impacted, whether it is a recovering addict themselves, whether it is a parent who has lost an adult child, whether it is healthcare professionals, or whether it is principals and teachers. My question to you is, yes, it is important to educate our youth about risks associated with drug abuse, but I also think it is important that parents, teacher, guidance counselors, employers, managers, have resources and understand what the best practices are so they can identify this early, early enough to help an individual seek care.

Can you talk about what resources you wish you had and what best practices there are out there?

Ms. MINER. I wish that we had more beds available. When Dr. Wen had mentioned earlier about when a parent is ready and they say that they are ready to quit, it takes a lot for a parent to be able to come forth and say I can't do this anymore, I need help. And then for them to be told we have nothing for you, you are

going to have to wait weeks or sometimes you have to wait months, I have seen way too many overdoses because of the parents that are waiting. They go back to what they know, and that is the substance use to make them feel better.

We absolutely have to educate everyone that is involved with this person's life, whether that be the schools, the employers, the community resource centers, anyone who comes in contact with this family, we have got to educate them and really talk about what it might look like, you know, if little Johnny is getting to school later and later, or he is missing more and more school, could there be a problem. And how the schools or whoever is coming in contact with this family can approach that child without it feeling like it is an interrogation or feeling like they have done something wrong or that they are too afraid to tell on their parents.

Ms. STEFANIK. Let me ask you about the flip side for a parent being able to identify in their child, let us say a high school age child—I met with a recovering addict who was a nationally recognized athlete and had an injury. She went through an operation and was prescribed pain medication. That led to a downward spiral of addiction, in and out of jail. And she was a very powerful advocate about how her—she was very good at hiding it, she said. And her parents didn't know, her coaches weren't aware of this issue. How do we educate the parent in that situation, when the parent is not the addict, but they are the parent of a child who is the addict?

Ms. MINER. I would say just we have got to break the stigma about addiction. Everybody looks at addiction as a really bad, dirty, ugly thing and they don't look at that it could be something that is being prescribed, especially to our children by our doctor, because we trust these doctors with our children and they sometimes are the ones who are overprescribing our youth. And it is really about educating the parents and sitting down and talking to the parents about differences in what their attitudes or their behaviors might be like, how they are reacting to things. I know that in my own experience that when my daughters had started in their active addiction their behavior toward me changed. They became more aggressive toward me and wanted to argue with me about a lot more things than what they did prior to that.

Ms. STEFANIK. And, Dr. Cox, if you could follow up from a school's perspective, how do principals, teachers, coaches, guidance counselors, how do we arm them with the resources and the education they need to identify when a student is going down the path towards addiction?

Dr. COX. Well, again, it is part of a comprehensive education effort and that is a part of our total health curriculum that starts in elementary school where we talk about this. And we have the DARE program at fifth and eighth grade, but also it really gets intense in our high school health class where we have actually recovering addicts who speak to our students. Our sheriff comes in and talks about all the things that he has seen. So we try to give them the best information that we can so that they can at least be forewarned.

Ms. STEFANIK. So the students are forewarned, but how about teachers? Not the health teacher, but the average teacher in the school, do they have the resources and the education they need?

Dr. COX. Well, let me give an example of that. You know, we have made it part of our professional development. This year at the beginning of school we convened an opioid panel of community experts and we actually recorded that. So it has been made available for our schools to use to show our teachers. It gives them the facts and information. And then also—

Ms. STEFANIK. Thank you. My time has expired. I am sorry about that.

Dr. COX. Sure.

Chairman ROKITA. I thank the gentlelady. Time has expired. Mr. DeSaulnier, you are recognized for 5 minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. And as someone who has spent some time on this issue in the course of my public service, I just want to remind folks some startling numbers. The United States has 4 percent of the world's population, but we consume 80 percent of the opioids in the world. Since 2000, over 200,000 Americans have lost their lives to opioid addiction. Four out of five heroin users started with the opioids. In 1995, when OxyContin started, the abuse of opioids was nonexistent. Quickly thereafter it became a catastrophe for this country.

Ms. Miner, first to you. As the son of a parent who had addiction problems, whose struggle was stigma and shame, I just want to tell you how proud I am of your testimony and your life testimony. In getting over stigma and shame in my relationship with my dad, who was not as successful as you, he ultimately lost his life to addiction, we have come a long way. But you telling your story, but tell me what would have happened, do you think, as you reflect back, if that child welfare worker or public employee hadn't interceded the way he did, when he did? Where do you think your life might be right now?

Ms. MINER. I think that I would probably be dead or in prison. I really don't believe that I stood much of a chance had I not had that one person that truly believed me and saw something in me that I was not able to see in myself at that time and to offer the supports to me for me to remain clean.

Mr. DESAULNIER. So to take something that is very emotional and put it in that sort of actuarial perspective, and this goes to cost and responsibility and prevention, intervention is what we should be doing, but ultimately, Dr. Wen, as a physician we want to get to prevention and root cause.

So there is a recent story, very troubling, in The New Yorker, if it is true, it is titled "The Family That Built an Empire on Pain." It is about Purdue Pharma. My experience when then-Attorney General Kamala Harris and I were working on simply upgrading the prescription monitoring system in California, which came to us by a software engineer who was a constituent who lost two children who were hit by someone who was abusing and doctor shopping, all we wanted to do was have real-time information, so the Department of Justice, the pharmacist, the doctor, could see if anyone is abusing. It has been in effect now and it has worked. But it was obvious to me that the pharmaceutical industry and the lobbyists

in Sacramento did not want that to happen. And I intuitively thought that it was because they were making money on the lack of our knowledge.

So in this article they talk about their senior medical advisor, once publicly likening addiction of Oxycontin to celery, where he said if you take celery—he said this at an event at Columbia, talking about addiction and opioids—it is healthy for you, but if you blend it and put it in your arteries, inject it, it is bad for you. So in that article it also talks about the response from Purdue Pharma is that clients don't abuse it, drug users abuse it, which, Ms. Miner, strikes me as throwing it right back on the addict. And personal responsibility is also the people who sell this.

So could you talk to me a little bit about addiction, prevention, root cause, and what the ultimate cause is, and who pays for that?

Dr. WEN. We did not get to this problem of the opioid epidemic overnight. There are a lot of people who have to take responsibility, including me as a physician. I know that I overprescribed opioids because that is what I learned in my medical training to do. That is the culture in medicine that we have to work to change. Big Pharma, though, plays a big role in this as well. They had misleading advertising and perpetuated this pill for every pain culture. If you fall down and you bruise your knee, it is okay to have pain, you don't have to take it away with opioids. There is a risk, there is a side effect. That is something that we can all work to change today.

We have been talking a lot about education in schools. And if you ask a student do you think heroin is good or bad, probably they will know that heroin is bad. But when they see their parent or their caregiver taking pills for back pain, for dental pain, that is a culture that we also have to work to change.

Mr. DESAULNIER. So, Dr. Cox, you talked about generational addiction. So unlike tobacco, opioids we now know have addicted future generations, and people have benefitted, just like the tobacco industry, off of this addiction; not to ascribe blame, but trying to identify responsibility to get at prevention.

Dr. Wen, back to you as a public health official. Unlike tobacco, we need to go back upstream. If there was a settlement agreement some years down the road, and I know that there is litigation around the country from attorney generals, the cost seems so out of proportion to the public cost of healthcare around secondhand smoke.

Dr. WEN. We need much more investment and perhaps Big Pharma can help us to pay for the effects of addiction that they have helped to create.

Mr. DESAULNIER. Maybe they should be held responsible.

Thank you, Mr. Chairman.

Chairman ROKITA. I thank the gentleman. The gentleman from Wisconsin is recognized for 5 minutes.

Mr. GROTHMAN. Yes, a couple of questions. As has been mentioned, I don't know any child out there who gets through school without knowing that opiates are bad for you. Nevertheless, I would like—Dr. Cox said something before and I would like follow up. You mentioned you had DARE and other programs in your school system. Could you or anybody else be a little more animated

about what doesn't work? What are we wasting money on so we can stop wasting money on it and genuinely get people not involved in these opioids? Could you give me examples of things that don't, so you can—anybody have ideas of things that aren't working?

Dr. COX. I think that is a hard question to answer. I mean, you are talking about messaging to kids. And we don't really have mechanisms to know how the messages have been effective or not. It admittedly is a shotgun kind of approach.

Mr. GROTHMAN. It is a little shocking. It is shocking. You don't have any opinions on things that aren't working? I mean, I have read articles on things that aren't working. None of you up here knows things that are not working so we can stay away from them?

Dr. COX. Well, I will say I don't feel that anything we are currently doing is not working. You know, specifically from our DARE program we get lots of parental feedback on that, it creates a great relationship with our law enforcement community.

Mr. GROTHMAN. You might want to Google DARE a little bit and dig a little bit deeper.

Dr. COX. I am aware of what you are speaking about.

Mr. GROTHMAN. Okay. Next thing, I wonder if anybody could comment on the criminal end of this? I know in my area, at least in more liberal counties where a lot of the drug dealing is going on, it is sometimes amazing how little the penalties are and how people are getting off with very little. Does anybody want to comment on what we could do on the criminal justice side to maybe persuade people not to become dealers? Anybody have any comments on that?

Mr. ROBINSON. I think one of the things to get people not to be drug dealers, a lot of those—you know, if we have got somebody that is part of a criminal syndicate, we need to prosecute them and put them in jail. But most of the dealers that we see are people that are dealing to support their habit. So the best way to get those dealers not dealing is to put them into a treatment program, give them a job skills course to allow them to go back to work and have a different way to support themselves than dealing drugs. And we have a lot of petty drug dealers that are just supporting their habit.

Mr. GROTHMAN. I am talking about Milwaukee because I am from Wisconsin and obviously very, you know, "liberalish" and maybe "liberalish" judges, "liberalish" DA. I wonder whether around the country there is also a concern that there are areas of high drug dealing in which people are not receiving appropriate sentences. Given the huge number of people who are dying does anybody feel that you have seen not enough people being thrown in prison for, as a practical matter, killing people?

Mr. ROBINSON. In Kentucky, we have broke our corrections budget in most of our counties. The county executives, their biggest cost that they are paying out is their jail budgets. I toured a jail a couple of weeks ago that had twice as many inmates as it was set up for because we have tried to incarcerate ourselves out of this. And we have to treat and then vocationally prepare people out of this problem.

Mr. GROTHMAN. Okay. I will give you one more question, because we are running out of time here. Are any of you aware of any stud-

ies of people who go through this? I know it can happen from any family, horrible things can happen in any family. But on the family background of both the dealers and the people who are, you know, arrested for possession, that sort of thing, do we have any studies on that? Any indications on, you know, where this disproportionately affects people?

Dr. WEN. We know that 8 out of 10 people who are in our jails in Maryland use illegal substances. Four out of 10 have mental health issues—

Mr. GROTHMAN. No—okay. Mental health is a big issue and what mental health issues are those?

Dr. WEN. It could be a combination of things, depression, schizophrenia, anxiety. They are often coexisting with substance abuse. And it is important for us to treat these diseases as the diseases that they are because an investment in public health is an investment in public safety. For every \$1 invested in treatment, it saves society \$12, including of criminal justice and incarceration costs.

Mr. GROTHMAN. Does anybody know any different on background of these people?

Mr. ROBINSON. When it comes to IV needle users, which are some of the folks that are most addicted, 80 percent of IV needle users today had a childhood trauma that is linked to their current issues. And so those early childhood traumas and not dealing with that is a major—

Mr. GROTHMAN. Can you describe trauma? Nobody knows what that means? What is a childhood trauma?

Chairman ROKITA. I think the gentleman's time has expired.

Mr. GROTHMAN. Yes. Could you—

Chairman ROKITA. The gentleman's time has expired. The gentlelady from Oregon is recognized for 5 minutes.

Ms. BONAMICI. Thank you, Mr. Chairman. Thank you to the witnesses, value all of your testimonies but, Ms. Miner, Mr. Robinson, thank you so much for being here and sharing your very personal stories. It takes courage to do that in such a public forum, but it really does make a difference.

I am from Oregon where, of course, this is affecting every community, not just urban, but also rural communities as well. In 2015, 180 people died from just prescription opioids in Oregon. That doesn't include the nonprescription. I just had a community discussion on opioids in Clatsop County, Oregon, which is a pretty rural coastal community. My constituent, Kerry Strickland, who I had met before, she created Jordan's Hope for Recovery. She lost her son Jordan—it started with a sports injury, following up on what my colleagues already mentioned—after a 7-year struggle with addiction and relapse. And her family's loss is just a reminder that we are talking about, you know real people and how this affects people in communities.

But there were some very common themes here about the inability—and we had this roundtable—the inability when people are ready, the inability to get them into treatment. And there are just too many barriers. Like you said, we know what to do, we just don't have the resources in many cases.

This crisis is tearing our families and communities apart, but it is not the first time. We went through this back; it was about 30

years ago, when the crack cocaine epidemic that disproportionately affected marginalized minority communities and, unfortunately, our country tended to respond with increased criminalization of abuse and addiction.

And, Dr. Wen, thank you for recognizing, as others have, that addiction is a disease, we should treat it as a disease. We know that our response then affected an entire generation of people and led to some pretty severe disadvantages and stalled educational progress and poor academic, employment, and life outcomes. So this is key, the conversation that we are having today.

You know, the President just declared that the opioid crisis is a public health emergency, but he didn't provide the financial resources that we need to fight the epidemic. So we don't just need a declaration. We need resources and we know where they need to go: prevention, recovery, treatment. And by bolstering the Affordable Care Act, for example, Medicaid, fully funding the Every Student Succeeds Act, programs that provide for health services for our students who are in schools - this is all really important.

I just visited a school-based health clinic in a high school in my district, and what a difference it makes for those students to have somewhere right there on campus where they can go, whether it be to talk to a counselor, get a vaccination, get healthcare right there on campus. It really makes a difference.

Dr. Cox and Dr. Wen, according to the original Adverse Childhood Experience, ACE, study by the CDC, individuals with 4 or more traumas were 12 times more likely to have attempted suicide, 7 times more likely to have alcoholism, and 10 times at greater risk for intravenous drug use. And we know that childhood traumas affect child brain development, children living in households, as we heard from Ms. Miner, with addiction are living in environments of chronic toxic stress.

So Warrenton-Hammond, which is a school district again in Clatsop County, in my district, is helping students by their incorporating trauma-informed practices into their school system. They have shifted from a punitive to a compassionate approach to school discipline, suspensions have gone down, attendance has improved.

So, Dr. Cox and Dr. Wen, you know that teachers and our school staff are oftentimes the first responders to the opioid epidemic. So are there tools and resources that teachers need to build around our knowledge of childhood trauma in order to be good first responders? And I want time for other questions.

Dr. WEN. In Baltimore City, we have started trauma-informed care trainings, including for all of our frontline city workers, such as our teachers. We have done now trainings for over 2,000 of our staff so far. It is important to shift the mentality, not look at someone as the perpetrator of violence, but rather as the victim of deep trauma. And that will help us to break the cycle that we talked about.

We also have to increase mental health services and substance abuse services in our schools, too. We have to provide services exactly where they are. In addition to recovery high schools, also increase services and screening right in our schools.

Ms. BONAMICI. Thank you. And, Dr. Cox, I want you to respond to this, during Every Student Succeeds Act reauthorization Con-

gress authorized Title IV-A at \$1.65 billion because members on both sides of the aisle understand the importance of these programs. Title IV-A is currently funded at \$400 million. Now, we have worked very closely with AASA, the School Superintendents Association, of which you are a member, to try to increase that funding. Isn't it important that Congress uphold its promise to get that funding so we can get these programs into schools?

Dr. COX. Absolutely. It is the position of AASA that we need the complete funding.

Ms. BONAMICI. Thank you. It is not just the flexibility, it is the funding.

And finally, I just want to close with a follow-up to the DARE program. I certainly hope it has been updated from its early '80s days because it was woefully ineffective. And I am hoping that it is——

Dr. COX. It has.

Ms. BONAMICI. To an evidence-based program. Because there are ways to figure out what works and what doesn't. And if it is evidence-based that would be useful.

I yield back. Thank you, Mr. Chairman.

Chairman ROKITA. The gentlelady's time has expired. The gentleman from Indiana is recognized for 5 minutes.

Mr. MESSER. Thank you, Chairman Rokita. I want to thank the panel for your testimony today and for your stamina as we get toward the end of today's hearing.

You know, in Indiana, opioids are wrecking communities and breaking hearts all across our State. President Trump was right to call this a public health emergency. And despite the hard work of our police, first responders, public health officials, and our schools, leadership all across these communities, the epidemic seems to have only gotten worse. I think we all can agree today that more needs to be done.

In Indiana, drug overdose fatalities have increased by more than 500 percent since 1999. And estimates of the total annual cost of overdoses exceeds \$1 billion just in my home State of Indiana alone. This crisis is crippling generations of Hoosiers and ripping apart their families and their communities.

In Indiana, I applaud recent steps by our Governor, Eric Holcomb, who in partnership with the Hoosier healthcare providers are working to tackle this public health crisis. Their approach is designed to decrease opioid deaths, increase awareness, and decrease the number of babies born with neonatal abstinence syndrome by devoting \$50 million over the next 5 years to this problem in our State.

A couple of quick questions. First, I wanted to start just with Dr. Cox. You gave testimony about some of the efforts in and around your school. How do you train teachers to counsel students who are coping with addiction themselves or who may have a family member dealing with the disease?

Dr. Cox. Well, it is difficult. You know, I think part of it is developing initial understanding of what it is because there is so much misunderstanding about addiction. And so that is what we have tried to do. And we don't have enough time resource for professional development. That is an issue as well. So it is not just the

money issue in terms of the professional development experience. But to answer your question, you know, we need to help our teachers understand what addiction is before they begin to help students and then refer them to counselors.

Mr. MESSER. And do you have family based programs, trying to get parents more engaged as well?

Dr. COX. We do. Again, our sheriff has done a really remarkable job in the community holding town hall meetings across the whole county. In fact, there is one this evening. And they have been well attended.

Mr. MESSER. Dr. Wen, I was hoping to just get any further recommendations. I mentioned in my introduction Indiana is working on a program to tackle these challenges. And I wonder if you had any further recommendations as we get to the end of this hearing for States who are looking to implement programs to prevent deaths and increase awareness?

Dr. WEN. The first thing that we have to do is get naloxone, the antidote, into the hands of every single individual, not only first responders, but we should all be able to carry it in our medicine cabinet, in our first aid kit, in our schools, in our libraries, similar to how we have defibrillators available at all these public places. But we also have to have funding so that we can get this lifesaving medication into the hands of everyone.

The second is we need to have treatment for people at the time that they need, all types of treatment that are evidence-based, which includes medication-assisted treatment that has been shown to reduce illness and prevent overdose deaths.

And the third is we critically have to fight stigma and encourage people to seek treatment. That also includes the prevention that we all talked about.

We were speaking about schools and what we can do at our schools. The Just Say No and programs such as that are not going to be enough. The education for teachers will not be enough unless we also promote wellbeing overall, so that we provide children and families the support that they need in terms of food and housing and other critical services.

Mr. MESSER. I do have to say to that, quickly, that I grew up in 1980s. I am a child of the 1980s and I remember the Just Say No program. Frankly, I think it mattered. I mean, the 1980s were a time when it wasn't cool to do drugs. Before that it was cool to do drugs. After that, you know, some said it was cool to do drugs. It wasn't cool then and I think it is part of the answer, not the only answer. And I appreciate the rest of the your testimony.

In the little limited time I have left, Mr. Robinson, I would just ask you to maybe comment a little further on the economic crisis that is being created by this opioid epidemic as well. I have talked to so many employers in my home State who are saying they are having a hard time finding the workforce they need because drugs is epidemic in their community.

Mr. ROBINSON. It is happening everywhere. And as I mentioned in my comments, our State chamber CEO says the number one economic concern in our State—and our State is moving forward with economic development, but one of the big concerns is are we going to, as jobs come, as companies expand, are we going to be able to

provide enough employees that can pass drug screens? And that is why I think one of the places that we need to look for workforce is people that are in addiction today. If we can treat them, then put them through vocational rehabilitation, and then get them a work ready program to put them back to work, then we can provide those employees that have been treated to those employers and meet this need.

Mr. MESSER. Yes. Thanks again. Thanks for your testimony. And thank you all for being here.

Chairman ROKITA. Thank you, gentlemen. The gentleman's time has expired.

Mr. Barletta, the gentleman from Pennsylvania, is recognized for 5 minutes.

Mr. BARLETTA. Thank you. Mr. Robinson, you hit on exactly what I am going to talk about right now. Whenever I sit down with Pennsylvania business owners they tell me that a major roadblock in job growth in recent years has been directly connected to the opioid crisis. These employers have good paying jobs that they desperately need to fill, but they can't find people who can pass a drug test for hiring.

Now, Pennsylvania is not alone in this crisis. Economist Alan Krueger identified national labor force participation for men aged 24–54 has fallen more in counties across America where more opioid pain medicine is prescribed. Chair of the Federal Reserve, Janet Yellen, has also acknowledged the opioid epidemic's tragic and devastating effects on the workforce. Now, clearly there needs to be a plan of action to treat these folks so that they could work again.

Mr. Robinson, in your testimony you shared how the CEO of the Kentucky Chamber of Commerce identified addiction as Kentucky's number one economic concern. What kind of partnerships has the Addiction Recovery Center formed with Kentucky workforce development boards to connect individuals who can pass a drug test with employers? And do you have any suggestions for how business owners in Pennsylvania and across the country can find qualified individuals to fill their open positions?

Mr. ROBINSON. I think our workforce development boards need to be as involved in this opioid issue as the healthcare side of this because treatment is essential. We can't get somebody back to work without treating them, but we also have to be able to give them an economic opportunity. And so I think the workforce boards is the logical place for us to put funding that allows them to work not only with treatment providers like us and those that are doing workforce programs, but also to work with those employers and to help us in this change in the culture because there are a lot of employers that have zero tolerance programs. Those zero tolerance programs are not going to work in the current reality moving forward.

And so we need to get those employers to start hiring some recovering addicts because then they will see what I have seen. A third of my workforce is recovering addicts and they are my best employees.

And so by getting those employers engaged—and we get them to the table by saying, look, if you will give second chances, we will

help you with the programs, the workforce programs, that you need to provide you with welders and truck drivers and some of these high-demand fields, healthcare, that they are suffering to fill those jobs.

Mr. BARLETTA. Yes, and I agree. And I think the first step is getting help for people. So the public and employers and our country as a Nation understand that it is a disease and an illness. These are not people who are losers and decide they want to wreck their lives with drugs. This is an illness, and as a country we need to understand that. Get people help, treatment, and then give them another shot at life.

Mr. ROBINSON. And we found as we have had people come into treatment, stick around and do our workforce program, it is not 1 in 5 or 1 in 10. There is a significant number of people coming into our residential centers. If given a career path at the time of treatment and knowing that they are going to be able to make a living on the other side of it, it increases treatment motivation. And those become some of the most successful people that we have in our communities.

Mr. BARLETTA. Well, the worst thing we can do as a Nation is help people and get them treatment and then slam a door in their face after they have gone through that when they are looking for another chance.

Thank you.

Mr. ROBINSON. Absolutely.

Chairman ROKITA. I thank the gentleman. The gentleman yields back.

I would like to again thank our witnesses for taking the time to be here with our subcommittees today.

I recognize Mr. Polis for closing remarks.

Mr. POLIS. I want to thank our witnesses for being here today and your compelling testimony, which will also appear in the official congressional record for the benefit of members who don't serve on this committee and members who were unable to attend. Each of you shared stories and data about your work and about the individuals that are impacted by the opioid crisis.

In my own community, like for so many of us, the opioid crisis has become very personal. For instance, my constituent Carlos Santos. When Carlos was in high school he was severely injured while playing in Summit County High School's homecoming football game. During his recovery process, he was prescribed habit-forming pain medications that later became an addiction. For years Carlos kept finding the pills to continue his habit until his entire life and health revolved around his addiction. It took a serious drunk driving accident to finally give Carlos a wake-up call that he needed to change his life. Now, years later, Carlos has successfully battled his addiction. But we all know that many others aren't as lucky and many pay the ultimate price.

As policymakers it is important to hear and share these stories, but we also have a responsibility to take these words and turn them into action. Throughout this hearing we have heard about how critical funding programs are for tackling this national crisis. To truly defeat this epidemic we need to fully fund programs that include the educational programs we have authorized in ESSA that

we have talked about today, mental health and treatment programs; research to study pain management alternatives like cannabis and others; and, of course, fully fund and support Medicaid, which, of course, provides funding to organizations like Mr. Robinson's.

I look forward to continuing to work with my Democratic and Republican colleagues towards the goal of ending the scourge of opioid and substance abuse across the country.

And I yield back the balance of my time.

Chairman ROKITA. I thank the gentleman. Let me also add my comments and close out this hearing. Again, thank each of you for your leadership, your courage for coming here today and helping not only these subcommittees and this committee as a whole and this Congress learn more about this crisis, this emergency, but your help to the entire Nation. You are, as has been said in this hearing, on the front lines. And funding and all that surely will continue to be discussed and debated.

But one thing is for sure that I learned in this hearing, is that you are the solutions, we are the solutions as a community. That one-size-fits-all approach certainly won't be helpful to this coming from Washington alone. So thank you again for your leadership.

Thank you for sharing your experiences with us. As my colleague, who sat in the chair here for a while, Mr. Brat, mentioned one of the bills we have been working to update—and apologies we did not speak more about it in terms of how it could help—is the Juvenile Justice and Delinquency Prevention Act. Your testimony today highlights the need for reforms that encourage community collaboration and engagement. And we have done this in H.R. 1809. So this is just one example of how Congress can be supportive, as the gentleman mentions, to communities in responding to unique local needs.

Again, your testimony has been invaluable as we learn more about how communities are coming together at the local level to address this epidemic, and it informs our discussions as we consider the next steps, including any legislation to help you do your jobs better, be the leaders that you are.

So thank you again for everything that each of you do and all the people that you represent who are doing very similar work.

Hearing no other business before us—

Mr. POLIS. Mr. Chairman, I do have a unanimous consent request. I ask unanimous consent to insert in the record a letter discussing the importance of the Medicaid expansion signed by numerous health and education organizations.

Chairman ROKITA. I thank the gentleman. Without objection, so admitted.

And having no other business before the committee we are adjourned for the day. Thank you very much.

[Additional submission by Ms. Adams follows:]

TIME

President Trump's Says He Wants to Stop the Opioid Crisis. His Actions Don't Match

By Dr. Mary T. Bassett, Dr. Julie Morita and Dr. Barbara Ferrer November 2, 2017

Dr. Mary T. Bassett is the Commissioner of Health for New York City, a position she assumed in February 2014. With more than 30 years of experience in public health, Dr. Bassett has dedicated her career to advancing health equity.

IDEAS *Dr. Julie Morita was appointed as commissioner of the Chicago Department of Public Health (CDPH) in early 2015; under Dr. Morita's leadership, CDPH developed and launched Healthy Chicago 2.0, a four-year plan to assure health equity by addressing the social determinants of health.*

Dr. Barbara Ferrer leads the Los Angeles County Department of Public Health which protects and promotes health and prevents disease among L.A. County's more than 10 million residents. Dr. Ferrer has over three decades of experience as a philanthropic strategist, public health director, researcher, and community advocate.

President Trump's declaration of opioids as a public health emergency left jurisdictions across the country – including New York City, Los Angeles and Chicago, the cities and county we serve as health commissioners and director – scrambling to understand the actual impact that this legal action will have on our response to an alarming increase in drug overdose deaths. In our cities, 2,650 people died last year of a drug overdose, the largest number on record.

Given the public health emergency designation, answers to three basic questions will determine the significance of this action: How much funding for public health responses will states and cities actually be able to access to support a long-term response to this deadly epidemic; how those dollars can be used; and for how long new funds will be available.

To be clear, the President's declaration of a public health emergency is an overdue recognition of the reality of the opioid epidemic in our cities and across the country. But it is definitely short from the much anticipated declaration of national emergency the President had promised, and without much-needed resources to expand effective interventions it will be largely symbolic.

The President's commission on combating the opioid epidemic has reportedly finalized a 53-page recommendation document that will guide the implementation of this plan. While we wait for official details, we remain very concerned about the future of another crucial piece in our nation's response to the alarming increase in overdose deaths: Medicaid – perhaps the most significant source of funds to treat opioid addiction.

In his speech last week, the President prompted Americans to know that the federal government “is aggressively fighting the opioid epidemic on all fronts.” As we assess the President's announcement, we must remember that the true test of how seriously our country takes the opioid crisis will come down to our commitment to preserve our public insurance program for low-income people.

Ironically, just as President Trump hypes his announcement, at the same time – in a position drastically at odds with a plan to combat the opioid crisis – he is still pressuring Congress to make extensive cuts to Medicaid. His tax plan, now being debated by Congress, includes a substantial \$1 trillion cut to the program by 2026. His Administration has also overtly advocated for including cuts to Medicaid in a new health care bill. While not in the headlines at the moment, the legislative push for repealing the Affordable Care Act is far from over. In his announcement of an executive order on health care two weeks ago, the President promised a new bill “in the coming months” that will have broad support from the GOP; if the two failed

health care bills are any indication of what is to come, an ACA repeal will slash Medicaid by hundreds of billions of dollars.

If the President succeeds at dismantling Medicaid, the emergency declaration will do little to reverse America's upward trend of overdose deaths.

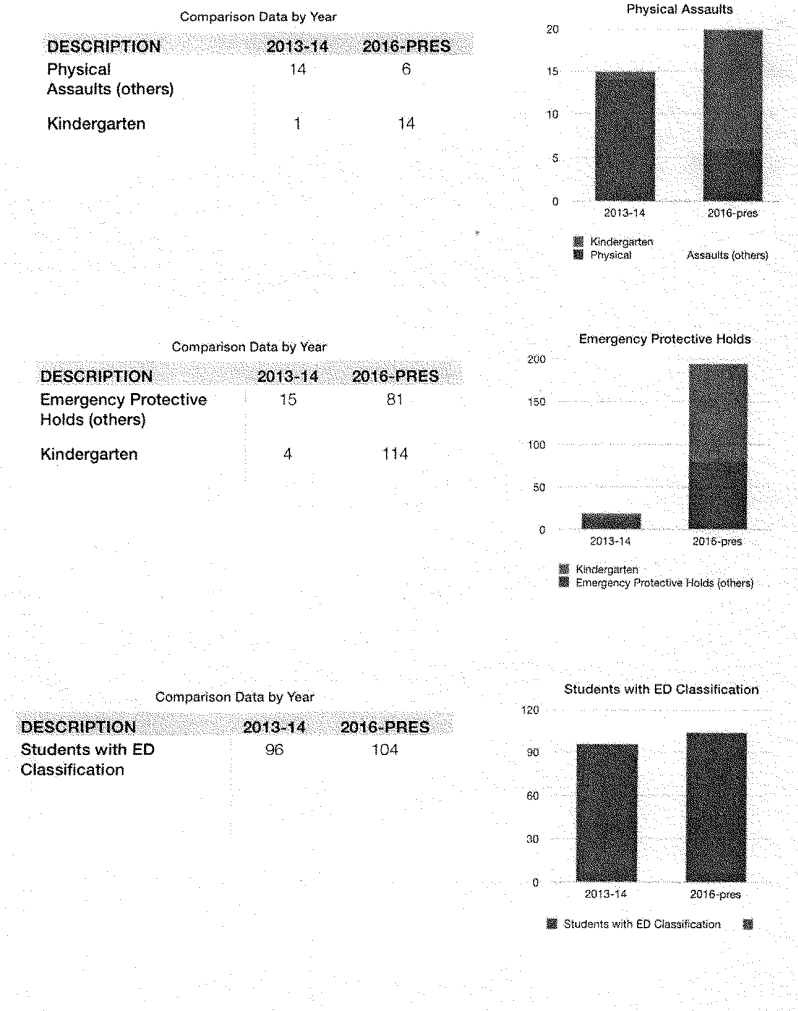
Medicaid has given millions of Americans access to substance use disorder treatment, providing health care coverage to some 3 in 10 people with opioid addiction in 2015. The program covers addiction treatment services, including reimbursement for the life-saving medications buprenorphine, methadone and naloxone. It also helps fund other approaches that we know work – including raising awareness and reducing stigma about drug use and distributing naloxone, an emergency medication to reverse overdose. Currently, over half of the states have increased access for Medicaid enrollees to naloxone. This is not just about the urban centers we serve; a cut to Medicaid is going to be felt in other parts of the country where the epidemic is acute, from New Mexico to New Hampshire.

For a full and honest response to the opioid crisis, we urge President Trump to support the bipartisan health care bill currently before the Senate, which would not change the number of people with Medicaid or private health insurance coverage. The President's support of this bill, along with the emergency declaration, will protect access to health insurance for people with drug addiction and at risk of an overdose. We cannot risk their lives. Our leaders in Washington must continue to give Americans the resources they need to get effective care to prevent overdose and treat addiction. Without a true commitment to reverse this deadly trend, these entirely preventable deaths will continue to soar.

IDEAS

TIME Ideas hosts the world's leading voices, providing commentary on events in news, society, and culture. We welcome outside contributions. Opinions expressed do not necessarily reflect the views of TIME editors.

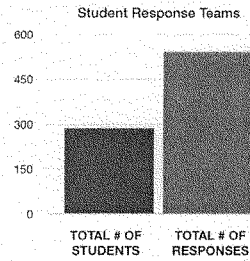
[Additional submission by Mr. Courtney follows:]



Memorial

DESCRIPTION

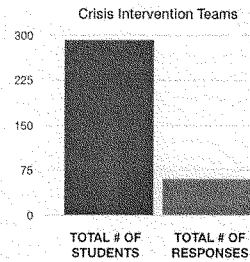
Total # of Students	288
10/19/2016 - 1/12/2017	542



Enfield Street School

DESCRIPTION

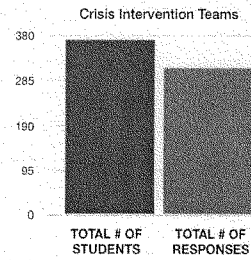
Total # of Students	292
12/7/2016 - 1/11/2017	60



Henry Barnard School

DESCRIPTION

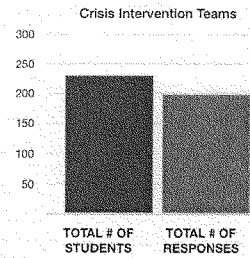
Total # of Students	371
52 DAYS	312



Nathan Hale School

DESCRIPTION

Total # of Students	230
11/9/16 - 1/13/17	198



[Additional submission by Ms. Davis follows:]

State Health Reform Assistance Network

Charting the Road to Coverage

A Robert Wood Johnson Foundation program

ISSUE BRIEF
July 2016

Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis

Prepared by *Deborah Bachrach, Patricia Boozang, and Mindy Lipson, Manatt Health*

Introduction

The United States is in the throes of a rapidly worsening opioid epidemic. The crisis is far-reaching: as of 2014, 1.9 million Americans had an opioid use disorder involving prescription medication, and an additional 19.6 million Americans had a substance use disorder (SUD) outside of addiction to prescription opioids.¹ Since 1999, the number of opioid overdoses resulting in death has increased by more than threefold for men and fivefold for women.² None of this is lost on state Medicaid officials. Even before the Affordable Care Act's (ACA) Medicaid expansion, Medicaid was the largest source of coverage for behavioral health services, including those related to SUDs. And Medicaid has taken on an even bigger role since passage of the ACA: in the 31 states that have expanded, 1.2 million individuals with SUDs have gained access to coverage.^{3,4}

This paper reviews Medicaid strategies to combat the opioid epidemic. Our primary focus is the important role Medicaid can play and is playing in combatting the opioid epidemic; however, it must be acknowledged that Medicaid is a far more powerful weapon in states that have expanded their Medicaid programs to all adults with incomes up to 138 percent of the federal poverty level (FPL). At least 1.1 million adults with SUDs reside in non-expansion states.⁵

Background

Medicaid covers over 70 million people—nearly 22 percent of the United States population—and is the largest payer in most states, with total annual spending of nearly \$500 billion nationwide.⁶ Medicaid is also the largest source of funding for behavioral health treatment in the country, paying approximately \$60 billion in 2014 for behavioral health services, including those related to SUDs.⁷ In short, throughout the nation, Medicaid is the most significant source of coverage and funding for critical substance use prevention and treatment.

Medicaid expansion under the ACA has amplified Medicaid's role in fighting the opioid epidemic. The expansion population—largely single adults not traditionally covered under Medicaid before the ACA—has a higher prevalence of SUDs than populations previously eligible for Medicaid. Now, with expansion, these adults have access to comprehensive insurance coverage, and states can thereby rely on Medicaid funds to cover the cost of prevention and treatment.⁸ Without Medicaid expansion, states are forced to rely on limited state general funds to provide SUD services to uninsured adults. In addition, prior to expansion, a number of states limited SUD coverage to pregnant women. By

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statelibrary.org.

ABOUT MANATT HEALTH
Manatt Health is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Manatt Health helps clients develop and implement strategies to address their greatest challenges, improve performance, and position themselves for long-term sustainability and growth. For more information, visit www.manatt.com/ManattHealth.aspx.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION
For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

For more information, please contact Deborah Bachrach at dbachrach@manatt.com or 212.790.4594, or Patricia Boozang at pboozang@manatt.com or 212.790.4523.

contrast, expansion adults receive the alternative benefit plan or ABP which covers the ACA's 10 essential health benefits, including SUD services. And expansion states are tapping into federal Medicaid funds to cover SUD prevention and treatment as well as the full range of comorbid physical and mental health conditions that come with substance use.¹¹

"The best way to get treatment if you're addicted to drugs in Missouri is to get pregnant."¹²

-Dr. Joe Parks, Director of MO HealthNet (Missouri Medicaid)
Note: Missouri has not expanded its Medicaid program.

As a major source of coverage and payment in all states—especially expansion states—Medicaid programs are answering the charge to fight the opioid epidemic. This report outlines tools that state Medicaid programs can use to prevent and treat opioid use disorders ranging from modest, but meaningful strategies for SUD prevention and treatment, to more innovative and transformative changes to the way that Medicaid pays for and delivers SUD services. Today, under their Medicaid State Plans, Medicaid agencies are enhancing coverage and benefits for those who are at the highest risk of or already grappling with SUDs; implementing Health Homes to provide care management services for individuals with SUDs; and leveraging Medicaid's purchasing power to require Medicaid providers and plans to promote best practices in SUD treatment. To institute broader reforms, Medicaid agencies are applying for and implementing SUD-focused Section 1115 demonstration waivers to transform their entire SUD delivery systems.¹³ The Centers for Medicare and Medicaid Services (CMS) has matched and supported state efforts to address the opioid epidemic not only through waiver design and approvals, but also through the technical assistance provided by the Innovator Accelerator Program (IAP).¹⁴ (We provide an overview of recent CMS guidance on strategies to address the opioid epidemic and other SUDs in Appendix A to this report.)

Uninsured individuals living in non-expansion states are less likely to obtain treatment for mental illness and substance use disorders as compared to insured individuals living in the same states.¹⁵ Up to 1.1 million additional individuals with an SUD would be newly eligible for Medicaid coverage if all states were to participate in Medicaid expansion.¹⁶

In states that have expanded, justice-involved populations are generally eligible for Medicaid upon their release. This fact is central to the SUD crisis: 68 percent of inmates of jails and 50 percent of inmates in state prisons have an SUD.¹⁷ With the implementation of Medicaid expansion in 2014, the rate of justice-involved populations that were uninsured dropped by 10 percentage points.¹⁸

State plan strategies

Through the straightforward mechanism of State Plan Amendments (SPA), state Medicaid agencies can design and pay for a wide range of programs to address the opioid epidemic and other SUDs.

COVERAGE AND BENEFITS

Under Medicaid law, states have the opportunity to tailor their benefit packages to improve SUD prevention and treatment. Specifically, states may:

- **Implement prior authorization requirements, institute quantity limits, and strengthen utilization review criteria for opioid prescriptions.**¹⁹
- **Expand Medicaid's access to and use of the state's Prescription Drug Monitoring Program (PDMP), a state database containing information about prescriptions for controlled substances, to identify Medicaid enrolled individuals who may be at-risk of opioid abuse and providers with lenient prescribing practices.**²⁰ Washington state's Medicaid agency is using its PDMP to identify beneficiaries with frequent controlled substance prescriptions, as well as providers that write an above average number of prescriptions. In addition, through its PDMP, Washington can recognize when a pharmacy has dispensed multiple controlled substance prescriptions to one individual in a short period, including when an individual uses Medicaid to pay for one prescription and cash for another.²¹
- **Improve timely access to medications used in medication-assisted treatment (MAT) by eliminating or modifying prior authorization requirements, and reviewing prescription drug policies to ensure that they are evidence-based and do not impose lifetime, duration, or quantity limits for MAT drugs that are not clinically indicated.**²² To facilitate use of MAT, Medicaid programs in Ohio and Texas have also issued detailed provider guidance on MAT billing procedures.²³
- **Add all forms of naloxone, a drug that can reverse an opioid overdose, and other evidence-based medications for opioid overdose to their preferred drug lists.**²⁴ Multiple forms of naloxone are on the preferred drug list in California and New York, among other states.²⁵

2 | Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis

HEALTH HOMES

Under the ACA, state Medicaid programs can implement Health Homes to provide robust care management services to individuals with chronic conditions, including individuals with SUDs. In the first two years of an individual's enrollment in a Health Home, states are able to access 90 percent federal matching funds. (And of course, for expansion adults, Health Home services will always be eligible for enhanced match.)

States are customizing Health Home SPA design and eligibility criteria to target enrollees with SUDs. Maryland, Rhode Island, and Vermont have implemented Health Home programs specifically for individuals with opioid use disorders and in doing so are providing the following services:

- **Intensive care management and care coordination** for individuals with opioid use disorders. These services include individualized care plans; helping patients navigate care across primary care providers, behavioral health providers, and community-based organizations; conducting outreach to beneficiaries who would benefit from MAT; and enrolling eligible individuals in opioid treatment programs.²⁴
- **Provider and workforce education** on evidence-based treatment for opioid use disorders. Training and education activities cover topics including health literacy, motivational interviewing, and care management for beneficiaries with opioid use disorders.²⁵

LEVERAGING MEDICAID'S PURCHASING POWER

States can accelerate changes to Medicaid SUD coverage and benefits by leveraging Medicaid's purchasing power to ensure that providers and plans are meeting best practices for SUD prevention and treatment. For example, California requires providers participating in the state's SUD pilot program to incorporate at least two evidence-based SUD treatment practices, such as motivational interviewing or cognitive-behavioral therapy, into care for patients with SUDs.²⁶

Given SUD provider capacity and access barriers in most states, Medicaid agencies can also endeavor to expand SUD provider participation in Medicaid (and increase capacity among existing providers) by increasing Medicaid payment rates, as the state of New Jersey has done. In his fiscal year 2017 budget, Governor Christie proposes a \$74 million increase in Medicaid rates for SUD services with the stated purpose of increasing access to substance use treatment.²⁷ States can go further in SUD delivery system reform by enhancing payment rates for providers that meet core SUD prevention and treatment best practices, as many states have done for providers meeting patient-centered medical home (PCMH) standards.²⁸ Notably, new Medicaid managed care (MMC) regulations provide states with the authority to require health plans to contract with certain providers, pay providers more for high-priority services, and provide incentives to plans that meet certain metrics.²⁹ States may deploy all of these tools to ensure that their MMC plans provide comprehensive quality care to enrollees with SUDs.

In addition, several states including New York, Florida, and Arizona have designed special plans for individuals with serious mental illness (SMI) and SUDs. These plans are required to provide services targeted to the special needs of these complex populations including interventions that address the social determinants of health. It should be noted that depending on the complexity or range of services, some strategies require using waiver authority, not just an SPA.

Demonstration waiver strategies

Section 1115 demonstration waivers provide states with a pathway and funding to undertake more far-reaching transformation of their SUD delivery systems. In July 2015, CMS issued a State Medicaid Director letter encouraging states to apply for new 1115 demonstrations that would "promote both systemic and practice reforms in their efforts to develop a continuum of care that effectively treats the physical, behavioral, and mental dimensions of SUD."³⁰

States pursuing these waivers must: develop an evidence-based SUD benefit package; ensure adequate networks for SUD services; provide care coordination services; develop a model for integrating physical health and SUD services; and institute other strategies to prevent and treat opioid use disorders. In conjunction with implementing comprehensive SUD delivery reform, a state may obtain an "IMD exclusion" waiver, which would permit a state to obtain federal matching funds for covering residential treatment services delivered at an institution for mental disease (IMD).³² States are also incorporating strategies targeting SUDs into 1115 demonstrations aimed at broad-based reforms to the Medicaid payment and delivery system.

New Hampshire is in the early stages of implementing a five-year \$150 million Delivery System Reform Incentive Payment program 1115 waiver, under which it will create a series of regional integrated delivery networks with a specific focus on improving behavioral health care. The initiative's goals are to "build greater behavioral health capacity, improve integration of physical and behavioral health, and improve care transitions for Medicaid beneficiaries, inclusive of children, youth, and adults."³¹

States are using 1115 waivers to focus their SUD payment and delivery system reform efforts, draw down additional federal funding to support reform efforts, and hold providers accountable for meeting clinical quality and performance measures related to SUD prevention and treatment. Specific state waiver strategies include:

- **Establishing integrated delivery networks of physical health, behavioral health, and social service providers.** Through its Delivery System Reform Incentive Payment (DSRIP) waiver, New Hampshire is creating new regional integrated delivery networks to improve the continuum of care for Medicaid beneficiaries with SUDs. These networks will include primary care providers, SUD providers, community mental health centers, peer health workers, hospitals, community health centers, and community-based organizations to address the full spectrum of physical health, behavioral health, and unmet social needs.³³ In Massachusetts's draft 1115 waiver application, the state is seeking to create interdisciplinary care teams including physical health, behavioral health, social service, and long-term services and supports providers. In addition, new Medicaid accountable care organizations formed under Massachusetts's waiver will be required to have memoranda of understanding with "Behavioral Health Community Partners," to provide Health Home, SUD, and mental health services to beneficiaries with an SUD and/or SMI.³⁴
- **Strengthening behavioral health workforce capacity.** New Hampshire is requiring the establishment of statewide work groups to identify strategies for strengthening behavioral health workforce capacity. At a regional level, integrated delivery networks will leverage the work groups' recommendations to "develop regional approaches to closing the work force and technology gaps that impact the capacity for coordinated care management and information sharing among medical, behavioral, and social service providers." New Hampshire is also implementing workforce training and recruitment programs for providers and community-based organizations and law enforcement entities interacting with individuals with behavioral health conditions.³⁶ As part of its newly released 1115 waiver, Massachusetts is proposing to use DSRIP funds to train new members of its SUD workforce, including recovery coaches, recovery support navigators, and care managers. Massachusetts is also planning to conduct provider education to ensure that physical and mental health providers are aware of SUD treatment options.³⁷
- **Implementing targeted clinical programs for beneficiaries with SUDs.** States including New Hampshire and New York are using waivers to test a wide range of delivery models for fighting the opioid epidemic and other SUDs including: community re-entry for justice-involved populations, peer behavioral health, community-based stabilization, school-based mental health and substance abuse screening and intervention, integrated dual disorder treatment for SUDs and mental health conditions, integration of primary care and behavioral health services, and community-based withdrawal management.³⁸
- **Expanding SUD benefits.** States can also use 1115 waivers to offer coverage for services that may not be authorized under their standard Medicaid benefit packages or to populations that would not otherwise be eligible for Medicaid. California is using an 1115 waiver to provide the full range of services for SUDs recommended by the American Society of Addiction Medicine, including partial hospitalization services, residential treatment services (including those offered at an IMD), and recovery services.³⁹ Similarly, under its pending 1115 waiver, Massachusetts is seeking to increase its coverage of American Society of Addiction Medicine-recommended services and to obtain an IMD exclusion waiver.⁴⁰ Through its 1115 waiver, New Jersey is implementing a Medication Assisted Treatment Initiative, which makes MAT services available to adults with incomes up to 150 percent of the FPL who would otherwise have income above Medicaid limits.⁴¹
- **Increasing access to care management and care coordination services.** Under its DSRIP waiver, California requires that counties, the entities overseeing SUD delivery system reform, "[develop] a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e., withdrawal management, residential, outpatient) without disruptions to services."⁴² Massachusetts is also planning to strengthen care management and coordination services across its SUD delivery system as part of its forthcoming 1115 demonstration.⁴³

Under an 1115 waiver, California is implementing a pilot program called the Drug Medi-Cal Organized Delivery System, which enables counties to provide an enhanced set of evidence-based benefits to Medicaid beneficiaries with SUDs. The pilot aims to "demonstrate how organized substance use disorder care increases the success of [Drug Medi-Cal] beneficiaries while decreasing other system health care costs."³⁹

Conclusion

States are grappling day to day with the vast and deadly public health crisis. Medicaid is the most powerful vehicle available to states to fund coverage of prevention and treatment for their residents at risk for or actively battling opioid addiction. Through federal flexibility, states can create strategies that meet their specific needs, designed to augment other efforts underway. The greatest opportunity to address this crisis is in those states that have elected to expand Medicaid, given the greater reach of the program, additional tools available, and the increased availability of federal funds.

4 | Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis

End notes

- ¹ Substance Abuse and Mental Health Services Administration. "Substance Use Disorders." October 27, 2015. Accessed May 23, 2016. <http://www.samhsa.gov/disorders/substance-use>; Substance Abuse and Mental Health Services Administration. "Mental and Substance Use Disorders." March 8, 2016. Accessed May 23, 2016. <http://www.samhsa.gov/disorders>.
- ² Substance Abuse and Mental Health Services Administration. "Substance Use Disorders." October 27, 2015. Accessed May 23, 2016. <http://www.samhsa.gov/disorders/substance-use>.
- ³ Ali, Mir M., Ryan Mutter, and Judith L. Teich. *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition*. Rockville: Substance Abuse and Mental Health Services Administration, 2015. Accessed May 23, 2016. http://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf.
- ⁴ This figure includes the states that had expanded as of November 2015. Since November 2015, Montana has implemented its Medicaid expansion; Louisiana will effectuate coverage for expansion adults in July 2016.
- ⁵ Ali, Mir M., Ryan Mutter, and Judith L. Teich. *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition*. Rockville: Substance Abuse and Mental Health Services Administration, 2015. Accessed May 23, 2016. http://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf.
- ⁶ Centers for Medicare and Medicaid Services. "NHE Fact Sheet." December 03, 2015. Accessed May 23, 2016. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>; Centers for Medicare and Medicaid Services. *March 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*. Baltimore: Centers for Medicare and Medicaid Services, 2016. Accessed June 7, 2016. <https://www.medicare.gov/medicaid-chip-program-information/program-information/downloads/march-2016-enrollment-report.pdf>.
- ⁷ United States Government Accountability Office. *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*. Washington, D.C.: United States Government Accountability Office, 2015. Accessed May 23, 2016. <http://www.gao.gov/assets/680/670894.pdf>.
- ⁸ Busch, Susan H., Ellen Meara, Haiden A. Huskamp, and Colleen L. Barry. *Characteristics of Adults with Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA*. Psychiatr Serv. 64, no. 6 (2013 Jun 1): 1. Accessed May 25, 2016. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3672321/>.
- ⁹ Dey, Judith, Emily Rosenoff, Kristina West, Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich, and Albert Woodward. *Benefits of Medicaid Expansion for Behavioral Health*. Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2016. Accessed May 23, 2016. <https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf>.
- ¹⁰ Ali, Mir M., Ryan Mutter, and Judith L. Teich. *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition*. Rockville: Substance Abuse and Mental Health Services Administration, 2015. Accessed May 23, 2016. http://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf.
- ¹¹ Bachrach, Deborah, Patricia Boozang, Avi Herring, and Dori Glanz Reynier. *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*. Princeton: State Health Reform Assistance Network, 2016. Accessed June 7, 2016. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf1419087; Dey, Judith, Emily Rosenoff, Kristina West, Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich, and Albert Woodward. *Benefits of Medicaid Expansion for Behavioral Health*. Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2016. Accessed May 23, 2016. <https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf>.
- ¹² Levey, Noam N. "Fighting Obamacare, Many Red States Find Fewer Tools to Fight Opioid Addiction Epidemic." *Los Angeles Times*, June 13, 2016. Accessed June 14, 2016. <http://www.latimes.com/nation/la-na-opioids-obamacare-20160613-snap-story.html>. Note, Missouri is a non-expansion state.
- ¹³ Dey, Judith, Emily Rosenoff, Kristina West, Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich, and Albert Woodward. *Benefits of Medicaid Expansion for Behavioral Health*. Washington, D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2016. Accessed May 23, 2016. <https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf>.
- ¹⁴ Saloner, Brendan, Sachini N. Bandara, Emma E. McGinty, and Colleen L. Barry. "Justice-Involved Adults with Substance Use Disorders: Coverage Increased but Rates of Treatment Did Not in 2014." *Health Affairs* 35, no. 6 (June 2016): 1058-66. Accessed June 14, 2016. <http://content.healthaffairs.org/content/35/6/1058.full#ref-18>.
- ¹⁵ States can also use 1915(b), (c), (i), and (k) waivers to institute changes to coverage, delivery, and payment of SUD services. Centers for Medicare and Medicaid Services. *Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. Baltimore: Centers for Medicare and Medicaid Services, 2015. Accessed June 7, 2016. <https://www.medicare.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
- ¹⁶ Centers for Medicare and Medicaid Services. *Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. Baltimore: Centers for Medicare and Medicaid Services, 2015. Accessed June 7, 2016. <https://www.medicare.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
- ¹⁷ Wachino, Vikki. *Best Practices for Addressing Prescription Opioid Overdose, Misuse and Addiction*. Baltimore: Center for Medicaid and CHIP Services, 2016. Accessed May 24, 2016. <https://www.medicare.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; Mercer. *State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose*. Phoenix: Mercer, 2014. Accessed June 7, 2016. http://medicaiddirectors.org/wp-content/uploads/2015/07/namd_rx_abuse_report_october_2014.pdf; Mann, Cindy, Thomas Frieden, Pamela S. Hyde, Nora D. Volkow, and George F. Koob. *Medication Assisted Treatment for Substance Use Disorders*. Baltimore: Centers for Medicare and Medicaid Services, 2014. Accessed May 23, 2016. <https://www.medicare.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.
- ¹⁸ Wachino, Vikki. *Best Practices for Addressing Prescription Opioid Overdose, Misuse and Addiction*. Baltimore: Center for Medicaid and CHIP Services, 2016. Accessed May 24, 2016. <https://www.medicare.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; Mercer. *State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose*. Phoenix: Mercer, 2014. Accessed June 7, 2016. http://medicaiddirectors.org/wp-content/uploads/2015/07/namd_rx_abuse_report_october_2014.pdf; Alexander, G. Caleb, Shannon Frattaroli, and Andrea C. Gielen. *The Prescription Opioid Epidemic: An Evidence-Based Approach*. Baltimore: Johns Hopkins Bloomberg School of Public Health, 2015. Accessed June 5, 2016. <http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/opioid-epidemic-town-hall-2015/2015-prescription-opioid-epidemic-report.pdf>.

- ¹⁹ PDMP Center of Excellence at Brandeis University. *Notes from the Field: Using PDMPs to Improve Medical Care: Washington State's Data Sharing Initiative with Medicaid and Workers' Compensation*. Waltham: PDMP Center of Excellence at Brandeis University. 2013. Accessed June 20, 2016. http://www.pdmpexcellence.org/sites/all/pdfs/washington_nff_final.pdf.
- ²⁰ Substance Abuse and Mental Health Services Administration. *Medicaid Coverage and Financing of Medications Used to Treat Alcohol and Opioid Use Disorders*. Rockville: Substance Abuse and Mental Health Services Administration. 2014. Accessed May 24, 2016. <http://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/SMA14-4854>; Wachino, Vikki. *Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction*. Baltimore: Center for Medicaid and CHIP Services. 2016. Accessed May 24, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; Mercer, *State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose: A Report for the National Association of Medicaid Directors*. Phoenix: Mercer. 2014. Accessed May 24, 2016. http://medicaiddirectors.org/wp-content/uploads/2015/07/namd_rx_abuse_report_october_2014.pdf.
- ²¹ Mann, Cindy, Thomas Frieden, Pamela S. Hyde, Nora D. Volkow, and George F. Koob. *Medication Assisted Treatment for Substance Use Disorders*. Baltimore: Centers for Medicare and Medicaid Services. 2014. Accessed May 23, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>; Texas Health and Human Services Commission. "Medication Assisted Therapy (MAT) Providers: Changes Related to Medicaid MAT Benefits Effective February 1, 2011." 2011. Accessed June 20, 2016. <http://www.tdhsc.state.tx.us/MAT-Benefits.shtml>; McCarthy, John. *Medicaid Coverage for ODADAS Certified Providers Rendering Medication Assisted Treatment*. Columbus: Ohio Department of Job and Family Services. 2012. Accessed June 20, 2016. http://mha.ohio.gov/Portals/0/assets/Planning/Medicaid/policy-memo-on-changes-to-medication-assisted-treatment-6.28.12_2.pdf.
- ²² Wachino, Vikki. *Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction*. Baltimore: Center for Medicaid and CHIP Services. 2016. Accessed May 24, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; Mann, Cindy, Thomas Frieden, Pamela S. Hyde, Nora D. Volkow, and George F. Koob. *Medication Assisted Treatment for Substance Use Disorders*. Baltimore: Centers for Medicare and Medicaid Services. 2014. Accessed May 23, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.
- ²³ Centers for Medicare and Medicaid Services. *Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed June 7, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
- ²⁴ Rhode Island Executive Office of Health and Human Services. *Health Home State Plan Amendment: RI Opioid Treatment Program Health Home Services*. Baltimore: Centers for Medicare and Medicaid Services. 2013. Accessed May 25, 2016. <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/RI/RI-13-011-Att.pdf>; Vermont Agency of Human Services. *State Plan Amendment (SPA): VT Health Homes for Beneficiaries Receiving Medication Assisted Therapy for Opioid Addiction*. Baltimore: Centers for Medicare and Medicaid Services. 2013. Accessed May 25, 2016. <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VT/VT-13-001.pdf>.
- ²⁵ Moses, Kathy, and Julie Klebonis. *Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed May 23, 2016. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-for-opioid-dependency.pdf>.
- ²⁶ Centers for Medicare and Medicaid Services. *California Medi-Cal 2020 Demonstration Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed May 23, 2016. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-ca.pdf>.
- ²⁷ State of New Jersey. Office of the Governor. "Governor Christie Announces Expansion of Behavioral Health Homes." April 7, 2016. Accessed June 20, 2016. <http://nj.gov/governor/news/news/552016/approved/20160407c.html>.
- ²⁸ Takach, Mary. "About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations." *Health Affairs* 31, no. 11 (November 2012): 2432-40. Accessed June 15, 2016. <http://content.healthaffairs.org/content/31/11/2432.full>; Kaiser Family Foundation. "Mapping Medicaid Delivery System and Payment Reform." Accessed June 27, 2016. <http://kff.org/interactive/delivery-system-and-payment-reform/>.
- ²⁹ Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Final Rule. 81 Fed. Reg. 27,497 (May 6, 2016) (to be codified at 42 C.F.R. Parts 431, 433, 438, 440, 457, & 495).
- ³⁰ Centers for Medicare and Medicaid Services. *Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed June 7, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
- ³¹ New Hampshire Department of Health and Human Services. *New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver: Draft Project and Metrics Specification Guide*. Concord: New Hampshire Department of Health and Human Services. 2016. Accessed June 7, 2016. <http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrp-proj-metric-spec.pdf>.
- ³² Centers for Medicare and Medicaid Services. *Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed June 7, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.
- ³³ Centers for Medicare and Medicaid Services. *New Hampshire Building Capacity for Transformation Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services. 2016. Accessed May 23, 2016. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-building-capacity-transformation-ca.pdf>; New Hampshire Department of Health and Human Services. *New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver: Integrated Delivery Network Application*. Concord: New Hampshire Department of Health and Human Services. 2016. Accessed May 23, 2016. <http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrp-idn-application.pdf>.
- ³⁴ Commonwealth of Massachusetts. Executive Office of Health and Human Services, Office of Medicaid. *Section 1115 Demonstration Project Amendment and Extension Request*. Boston: Commonwealth of Massachusetts. Executive Office of Health and Human Services, Office of Medicaid. 2016. Accessed June 20, 2016. <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/06-15-16-section-1115-demonstration-extension-request.pdf>.
- ³⁵ Centers for Medicare and Medicaid Services. *California Medi-Cal 2020 Demonstration Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services. 2015. Accessed May 23, 2016. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-ca.pdf>.
- ³⁶ New Hampshire Department of Health and Human Services. *New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration: Attachment C: DSRIP Planning Protocol*. Concord: New Hampshire Department of Health and Human Services. 2016. Accessed May 23, 2016. <http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrp-plan-protocol-attach-c-draft-20160229.pdf>.

- ³⁷ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, *Section 1115 Demonstration Project Amendment and Extension Request*. Boston: Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, 2016. Accessed June 20, 2016. <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/06-15-16-section-1115-demonstration-extension-request.pdf>.
- ³⁸ New Hampshire Department of Health and Human Services. *New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration: Attachment C: DSRIP Planning Protocol*. Concord: New Hampshire Department of Health and Human Services, 2016. Accessed May 23, 2016. <http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrp-plan-protocol-attach-c-draft-20160229.pdf>. New York State Department of Health. *New York State Delivery System Reform Incentive Payment Program: Project Toolkit*. Albany: New York State Department of Health, 2014. Accessed June 5, 2016. http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_project_toolkit.pdf.
- ³⁹ Centers for Medicare and Medicaid Services. *California Medi-Cal 2020 Demonstration Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services, 2015. Accessed May 23, 2016. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-ca.pdf>.
- ⁴⁰ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, *Section 1115 Demonstration Project Amendment and Extension Request*. Boston: Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, 2016. Accessed June 20, 2016. <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/06-15-16-section-1115-demonstration-extension-request.pdf>.
- ⁴¹ Centers for Medicare and Medicaid Services. *New Jersey Comprehensive Waiver Demonstration Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services, 2016. Accessed June 7, 2016. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf>.
- ⁴² Centers for Medicare and Medicaid Services. *California Medi-Cal 2020 Demonstration Special Terms and Conditions*. Baltimore: Centers for Medicare and Medicaid Services, 2015. Accessed May 23, 2016. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-ca.pdf>.
- ⁴³ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, *Section 1115 Demonstration Project Amendment and Extension Request*. Boston: Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, 2016. Accessed June 20, 2016. <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/06-15-16-section-1115-demonstration-extension-request.pdf>.

Appendix A

CMS GUIDANCE ON MEDICAID COVERAGE FOR AND PAYMENT OF SUD SERVICES

In recent years, CMS has issued a significant amount of guidance specifically related to Medicaid coverage and payment of SUD services. The table below provides an overview of this guidance.

Title	Date	Type of Guidance	Topics Addressed in Guidance
Medication Assisted Treatment for Substance Use Disorders	July 11, 2014	Informational Bulletin (CMCS in conjunction with SAMHSA, CDC, NIH National Institute on Drug Abuse, and NIH National Institute on Alcohol Abuse and Alcoholism)	Provides an overview of the components of MAT, discusses options to improve beneficiaries' access to MAT, and reviews strategies that state Medicaid agencies can implement to prevent SUDs.
Coverage of Behavioral Health Services for Youth with Substance Use Disorder	January 26, 2015	Joint CMCS and SAMHSA Informational Bulletin	Describes the types of SUD treatment that state Medicaid agencies can consider including in their benefit package for youth, outlines potential financing mechanisms for covering SUD services to youth, and identifies quality measures assessing SUD treatment.
Coverage of Housing-Related Activities and Services for Individuals with Disabilities	June 26, 2015	CMCS Informational Bulletin	Provides an overview of the types of housing services that state Medicaid programs may be interested in covering and identifies mechanisms for reimbursing these services under Medicaid.
New Service Delivery Opportunities for Individuals with a Substance Use Disorder	July 27, 2015	State Medicaid Director Letter	Provides information on the goals and requirements for SUD transformation 1115 waivers and identifies conditions for states to obtain IMD exclusion waivers.
Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction	January 28, 2016	CMCS Informational Bulletin	Provides an overview of strategies that state Medicaid programs can implement to address the opioid epidemic, including those related to pharmacy benefit management, access to naloxone, and coverage of MAT.

Notes

CMCS = Center for Medicaid and CHIP Services

SAMHSA = Substance Abuse and Mental Health Services Administration

NIH = National Institutes of Health

[Additional submissions by Mr. Polis follows:]

11/7/2017

Medical Cannabis Laws and Opioid Mortality | Law and Medicine | JAMA Internal Medicine | The JAMA Network

Original Investigation

October 2014

Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010

Marcus A. Bachhuber, MD^{1,2,3}; Brendan Saloner, PhD^{3,4}; Chinazo O. Cunningham, MD, MS⁵; [et al](#)

Author Affiliations Article Information

JAMA Intern Med. 2014;174(10):1668-1673. doi:10.1001/jamainternmed.2014.4005

Abstract

Importance Opioid analgesic overdose mortality continues to rise in the United States, driven by increases in prescribing for chronic pain. Because chronic pain is a major indication for medical cannabis, laws that establish access to medical cannabis may change overdose mortality related to opioid analgesics in states that have enacted them.

Objective To determine the association between the presence of state medical cannabis laws and opioid analgesic overdose mortality.

Design, Setting, and Participants A time-series analysis was conducted of medical cannabis laws and state-level death certificate data in the United States from 1999 to 2010; all 50 states were included.

Exposures Presence of a law establishing a medical cannabis program in the state.

Main Outcomes and Measures Age-adjusted opioid analgesic overdose death rate per 100 000 population in each state. Regression models were developed including state and year fixed effects, the presence of 3 different policies regarding opioid analgesics, and the state-specific unemployment rate.

Results Three states (California, Oregon, and Washington) had medical cannabis laws effective prior to 1999. Ten states (Alaska, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Rhode Island, and Vermont) enacted medical cannabis laws between 1999 and 2010. States with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate (95% CI, -37.5% to -9.5%; $P = .003$) compared with states without medical cannabis laws. Examination of the association between medical cannabis laws and opioid analgesic overdose mortality in each year after implementation of the law showed that such laws were associated with a lower rate of overdose mortality that generally strengthened over time: year 1 (-19.9%; 95% CI, -30.6% to -7.7%; $P = .002$), year 2 (-25.2%; 95% CI, -40.6% to -5.9%; $P = .01$), year 3 (-23.6%; 95% CI, -41.1% to -1.0%; $P = .04$), year 4 (-20.2%; 95% CI, -33.6% to -4.0%; $P = .02$).

year 5 (−33.7%; 95% CI, −50.9% to −10.4%; $P = .008$), and year 6 (−33.3%; 95% CI, −44.7% to −19.6%; $P < .001$). In secondary analyses, the findings remained similar.

Conclusions and Relevance Medical cannabis laws are associated with significantly lower state-level opioid overdose mortality rates. Further investigation is required to determine how medical cannabis laws may interact with policies aimed at preventing opioid analgesic overdose.

Introduction

Chronic noncancer pain is common in the United States,¹ and the proportion of patients with noncancer pain who receive prescriptions for opioids has almost doubled over the past decade.² In parallel to this increase in prescriptions, rates of opioid use disorders and overdose deaths have risen dramatically.^{3,4} Policies such as prescription drug monitoring programs, increased scrutiny of patients and providers, and enhanced access to substance abuse treatment have been advocated to reduce the risk of opioid analgesics⁵; however, relatively less attention has focused on how the availability of alternative nonopioid treatments may affect overdose rates.

As of July 2014, a total of 23 states have enacted laws establishing medical cannabis programs⁶ and chronic or severe pain is the primary indication in most states.⁷⁻¹⁰ Medical cannabis laws are associated with increased cannabis use among adults.¹¹ This increased access to medical cannabis may reduce opioid analgesic use by patients with chronic pain, and therefore reduce opioid analgesic overdoses. Alternatively, if cannabis adversely alters the pharmacokinetics of opioids or serves as a “gateway” or “stepping stone” leading to further substance use,¹²⁻¹⁴ medical cannabis laws may increase opioid analgesic overdoses. Given these potential effects, we examined the relationship between implementation of state medical cannabis laws and opioid analgesic overdose deaths in the United States between 1999 and 2010.

Methods

The opioid analgesic overdose mortality rate in each state from 1999 to 2010 was abstracted using the Wide-ranging Online Data for Epidemiologic Research interface to multiple cause-of-death data from the Centers for Disease Control and Prevention.¹⁵ We defined opioid analgesic overdose deaths as fatal drug overdoses of any intent (*International Statistical Classification of Diseases, 10th revision* [ICD-10], codes X40-X44, X60-X64, and Y10-Y14) where an opioid analgesic was also coded (T40.2-T40.4). This captures all overdose deaths where an opioid analgesic was involved including those involving polypharmacy or illicit drug use (eg, heroin). Analysis of publicly available secondary data is considered exempt by the University of Pennsylvania Institutional Review Board.

Three states (California, Oregon, and Washington) had medical cannabis laws effective prior to 1999.⁶ Ten states (Alaska, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Rhode Island, and Vermont) implemented medical cannabis laws between 1999 and 2010. Nine states (Arizona, Connecticut,

Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, and New York) had medical cannabis laws effective after 2010, which is beyond the study period. New Jersey's medical cannabis law went into effect in the last quarter of 2010 and was counted as effective after the study period. In each year, we first plotted the mean age-adjusted opioid analgesic overdose mortality rate in states that had a medical cannabis law vs states that did not.

Next, we determined the association between medical cannabis laws and opioid analgesic–related deaths using linear time-series regression models. For the dependent variable, we used the logarithm of the year- and state-specific age-adjusted opioid analgesic overdose mortality rate. Our main independent variable of interest was the presence of medical cannabis laws, which we modeled in 2 ways.

In our first regression model, we included an indicator for the presence of a medical cannabis law in the state and year. All years prior to a medical cannabis law were coded as 0 and all years after the year of passage were coded as 1. Because laws could be implemented at various points in the year, we coded the law as a fraction for years of implementation (eg, 0.5 for a law that was implemented on July 1). The coefficient on this variable therefore represents the mean difference, expressed as a percentage, in the annual opioid analgesic overdose mortality rate associated with the implementation of medical cannabis laws. To estimate the absolute difference in mortality associated with medical cannabis laws in 2010, we calculated the expected number of opioid analgesic overdose deaths in medical cannabis states had laws not been present and subtracted the actual number of overdose deaths recorded.

In our second model, we allowed the effect of medical cannabis laws to vary depending on the time elapsed since enactment, because states may have experienced delays in patient registration, distribution of identification cards, and establishment of dispensaries, if applicable. Accordingly, we coded years with no law present as 0, but included separate coefficients to measure each year since implementation of the medical cannabis law for states that adopted such laws. States that implemented medical cannabis laws before the study period were coded similarly (eg, in 1999, California was coded as 3 because the law was implemented in 1996). This model provides separate estimates for 1 year after implementation, 2 years after implementation, and so forth.

Each model adjusted for state and year (fixed effects). We also included 4 time-varying state-level factors: (1) the presence of a state-level prescription drug monitoring program (a state-level registry containing information on controlled substances prescribed in a state),¹⁶ (2) the presence of a law requiring or allowing a pharmacist to request patient identification before dispensing medications,¹⁷ (3) the presence of regulations establishing increased state oversight of pain management clinics,¹⁸ and (4) state- and year-specific unemployment rates to adjust for the economic climate.¹⁹ Collinearity among independent variables was assessed by examining variance inflation factors; no evidence of collinearity was found. For all models, robust standard errors were calculated using procedures to account for correlation within states over time.

To assess the robustness of our results, we performed several further analyses. First, we excluded intentional opioid analgesic overdose deaths from the age-adjusted overdose mortality rate to focus exclusively on nonsuicide deaths. Second, because heroin and prescription opioid use are interrelated for some individuals,²⁰⁻²³ we included overdose deaths related to heroin, even if no opioid analgesic was coded. Third, we assessed the robustness of our findings to the inclusion of state-specific linear time trends that can be used to adjust for differential factors that changed linearly over the study period (eg, hard-to-measure attitudes or cultural changes). Fourth, we tested whether trends in opioid analgesic overdose mortality predated the implementation of medical cannabis laws by including indicator variables in a separate regression model for the 2 years before the passage of the law.²⁴ Finally, to test the specificity of any association found between medical cannabis laws and opioid analgesic overdose mortality, we examined the association between state medical cannabis laws and age-adjusted death rates of other medical conditions without strong links to cannabis use: heart disease (ICD-10 codes I00-I09, I11, I13, and I20-I51)²⁵ and septicemia (A40-A41). All analyses were performed using SAS, version 9.3 (SAS Institute Inc).

Results

The mean age-adjusted opioid analgesic overdose mortality rate increased in states with and without medical cannabis laws during the study period (Figure 1). Throughout the study period, states with medical cannabis laws had a higher opioid analgesic overdose mortality rate and the rates rose for both groups; however, between 2009 and 2010 the rate in states with medical cannabis laws appeared to plateau.

In the adjusted model, medical cannabis laws were associated with a mean 24.8% lower annual rate of opioid analgesic overdose deaths (95% CI, -37.5% to -9.5%; $P = .003$) (Table), compared with states without laws. In 2010, this translated to an estimated 1729 (95% CI, 549 to 3151) fewer deaths than expected. Medical cannabis laws were associated with lower rates of opioid analgesic overdose mortality, which generally strengthened in the years after passage (Figure 2): year 1 (-19.9%; 95% CI, -30.6% to -7.7%; $P = .002$), year 2 (-25.2%; 95% CI, -40.6% to -5.9%; $P = .01$), year 3 (-23.6%; 95% CI, -41.1% to -1.0%; $P = .04$), year 4 (-20.2%; 95% CI, -33.6% to -4.0%; $P = .02$), year 5 (-33.7%; 95% CI, -50.9% to -10.4%; $P = .008$), and year 6 (-33.3%; 95% CI, -44.7% to -19.6%; $P < .001$). The other opioid analgesic policies, as well as state unemployment rates, were not significantly associated with opioid analgesic mortality rates.

In additional analyses, the association between medical cannabis laws and opioid analgesic mortality rates was similar after excluding intentional deaths (ie, suicide) and when including all heroin overdose deaths, even if an opioid analgesic was not involved (Table). Including state-specific linear time trends in the model resulted in a borderline significant association between laws and opioid analgesic overdose mortality (-17.9%; 95% CI, -32.7% to 0.3%; $P = .054$). When examining the years prior to law implementation, we did not find an association between medical cannabis laws and opioid analgesic overdose mortality 2 years prior to law implementation (-13.1%; 95% CI, -45.5% to 38.6%; $P = .56$) or 1 year prior (1.2%; 95% CI, -41.2% to 74.0%; $P = .97$). Finally, we did not find significant associations between medical cannabis laws and mortality

associated with heart disease (1.4%; 95% CI, -0.2% to 2.9%; $P = .09$) or septicemia (-1.8%; 95% CI, -7.6% to 4.3%; $P = .55$).

Discussion

In an analysis of death certificate data from 1999 to 2010, we found that states with medical cannabis laws had lower mean opioid analgesic overdose mortality rates compared with states without such laws. This finding persisted when excluding intentional overdose deaths (ie, suicide), suggesting that medical cannabis laws are associated with lower opioid analgesic overdose mortality among individuals using opioid analgesics for medical indications. Similarly, the association between medical cannabis laws and lower opioid analgesic overdose mortality rates persisted when including all deaths related to heroin, even if no opioid analgesic was present, indicating that lower rates of opioid analgesic overdose mortality were not offset by higher rates of heroin overdose mortality. Although the exact mechanism is unclear, our results suggest a link between medical cannabis laws and lower opioid analgesic overdose mortality.

Approximately 60% of all opioid analgesic overdoses occur among patients who have legitimate prescriptions from a single provider.²⁶ This group may be sensitive to medical cannabis laws; patients with chronic noncancer pain who would have otherwise initiated opioid analgesics may choose medical cannabis instead. Although evidence for the analgesic properties of cannabis is limited, it may provide analgesia for some individuals.^{27,28} In addition, patients already receiving opioid analgesics who start medical cannabis treatment may experience improved analgesia and decrease their opioid dose,^{29,30} thus potentially decreasing their dose-dependent risk of overdose.^{31,32} Finally, if medical cannabis laws lead to decreases in polypharmacy—particularly with benzodiazepines—in people taking opioid analgesics, overdose risk would be decreased. Further analyses examining the association between medical cannabis laws and patterns of opioid analgesic use and polypharmacy in the population as a whole and across different groups are needed.

A connection between medical cannabis laws and opioid analgesic overdose mortality among individuals who misuse or abuse opioids is less clear. Previous laboratory work has shown that cannabinoids act at least in part through an opioid receptor mechanism^{33,34} and that they increase dopamine concentrations in the nucleus accumbens in a fashion similar to that of heroin and several other drugs with abuse potential.^{33,35} Clinically, cannabis use is associated with modest reductions in opioid withdrawal symptoms for some people,^{36,37} and therefore may reduce opioid use. In contrast, cannabis use has been linked with increased use of other drugs, including opioids^{14,38-40}; however, a causal relationship has not been established.^{14,41} Increased access to cannabis through medical cannabis laws could influence opioid misuse in either direction, and further study is required.

Although the mean annual opioid analgesic overdose mortality rate was lower in states with medical cannabis laws compared with states without such laws, the findings of our secondary analyses deserve further consideration. State-specific characteristics, such as trends in attitudes or health behaviors, may explain variation in medical cannabis laws and opioid analgesic overdose mortality, and we found some

evidence that differences in these characteristics contributed to our findings. When including state-specific linear time trends in regression models, which are used to adjust for hard-to-measure confounders that change over time, the association between laws and opioid analgesic overdose mortality weakened. In contrast, we did not find evidence that states that passed medical cannabis laws had different overdose mortality rates in years prior to law passage, providing a temporal link between laws and changes in opioid analgesic overdose mortality. In addition, we did not find evidence that laws were associated with differences in mortality rates for unrelated conditions (heart disease and septicemia), suggesting that differences in opioid analgesic overdose mortality cannot be explained by broader changes in health. In summary, although we found a lower mean annual rate of opioid analgesic mortality in states with medical cannabis laws, a direct causal link cannot be established.

This study has several limitations. First, this analysis is ecologic and cannot adjust for characteristics of individuals within the states, such as socioeconomic status, race/ethnicity, or medical and psychiatric diagnoses. Although we found that the association between medical cannabis laws and lower opioid overdose mortality strengthened in the years after implementation, this could represent heterogeneity between states that passed laws earlier in the study period vs those that passed the laws later. Second, death certificate data may not correctly classify cases of opioid analgesic overdose deaths, and reporting of opioid analgesics on death certificates may differ among states; misclassification could bias our results in either direction. Third, although fixed-effects models can adjust for time-invariant characteristics of each state and state-invariant time effects, there may be important time- and state-varying confounders not included in our models. Finally, our findings apply to states that passed medical cannabis laws during the study period and the association between future laws and opioid analgesic overdose mortality may differ.

Conclusions

Although the present study provides evidence that medical cannabis laws are associated with reductions in opioid analgesic overdose mortality on a population level, proposed mechanisms for this association are speculative and rely on indirect evidence. Further rigorous evaluation of medical cannabis policies, including provisions that vary among states,^{14,42} is required before their wide adoption can be recommended. If the relationship between medical cannabis laws and opioid analgesic overdose mortality is substantiated in further work, enactment of laws to allow for use of medical cannabis may be advocated as part of a comprehensive package of policies to reduce the population risk of opioid analgesics.

Article Information

[Back to top](#)

Accepted for Publication: May 2, 2014.

Corresponding Author: Marcus A. Bachhuber, MD, Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, 423 Guardian Dr, 1303-A Blockley Hall, Philadelphia, PA 19104 (marcus.bachhuber@gmail.com).

Published Online: August 25, 2014. doi:10.1001/jamainternmed.2014.4005.

Author Contributions: Dr Bachhuber had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Bachhuber, Saloner, Barry.

Acquisition, analysis, or interpretation of data: Bachhuber, Cunningham, Barry.

Drafting of the manuscript: Bachhuber, Saloner.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Bachhuber, Saloner, Barry.

Study supervision: Cunningham, Barry.

Conflict of Interest Disclosures: Dr Cunningham's husband was recently employed by Pfizer Pharmaceuticals and is currently employed by Quest Diagnostics. No other disclosures are reported.

Funding/Support: This work was funded by National Institutes of Health (NIH) grants R01DA032110 and R25DA023021 and the Center for AIDS Research at the Albert Einstein College of Medicine and Montefiore Medical Center grant NIH AI-51519. Dr Saloner received funding support from the Robert Wood Johnson Foundation Health and Society Scholars Program. Dr Bachhuber received funding support from the Philadelphia Veterans Affairs Medical Center and the Robert Wood Johnson Foundation Clinical Scholars Program.

Role of the Sponsor: The sponsors had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The findings and conclusions of this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.

Corrections: This article was corrected on August 27, 2014, to fix a typographical error in Figure 1 and on September 10, 2014, to fix an incorrect term in the Discussion.

References

- 1.
- 2.
- 3.
- 4.
- 5.

May 2, 2017

Re: The American Health Care Act Vote

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Paul Ryan
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader McConnell, Speaker Ryan, Minority Leader Schumer, and Minority Leader Pelosi:

The undersigned member organizations of the Save Medicaid in the Schools Coalition are concerned that the American Health Care Act (AHCA) jeopardizes healthcare for the nation's most vulnerable children: students with disabilities and students in poverty. Specifically, the AHCA reneges on Medicaid's 50+ year commitment to provide America's children with access to vital healthcare services that ensure they have adequate educational opportunities and can contribute to society by imposing a per-capita cap and shifting current and future costs to taxpayers in every state and Congressional district. While children currently comprise almost half of all Medicaid beneficiaries, less than one in five dollars is spent by Medicaid on children. Accordingly, a per-capita cap, even one that is based on different groups of beneficiaries, will disproportionately harm children's access to care, including services received at school. **Considering these unintended consequences, we urge a 'no' vote on The American Health Care Act (AHCA).**

Medicaid is a cost-effective and efficient provider of essential health care services for children. School-based Medicaid programs serve as a lifeline to children who can't access critical health care and health services outside of their school. Under this bill, the bulk of the mandated costs of providing health care coverage would be shifted to the States even though health needs and costs of care for children will remain the same or increase. Most analyses of the AHCA project that the Medicaid funding shortfall in support of these mandated services will increase, placing states at greater risk year after year. The federal disinvestment in Medicaid imposed by the AHCA will force States and local communities to increase taxes and reduce or eliminate various programs and services, including other non-Medicaid services. The unintended consequences of the AHCA will force states to cut eligibility, services, and benefits for children.

The projected loss of \$880 billion in federal Medicaid dollars will compel States to ration health care for children. Under the per-capita caps included in the AHCA, health care will be rationed and schools will be forced to compete with other critical health care providers—hospitals, physicians, and clinics—that serve Medicaid-eligible children. School-based health services are mandated on the States and those mandates do not cease simply

because Medicaid funds are capped by the AHCA. As with many other unfunded mandates, capping Medicaid merely shifts the financial burden of providing services to the States.

Medicaid Enables Schools to Provide Critical Health Care for Students

A school's primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver health services effectively and efficiently since school is where children spend most of their days. Increasing access to health care services through Medicaid improves health care and educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

Since 1988, Medicaid has permitted payment to schools for certain medically-necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service program (IFSP). Schools are thus eligible to be reimbursed for direct medical services to Medicaid-eligible students with an IEP or IFSP. In addition, districts can receive Medicaid reimbursements for providing Early Periodic Screening Diagnostic and Treatment Benefits (EPSDT), which provide Medicaid-eligible children under age 21 with a broad array of diagnosis and treatment services. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problems become complex and treatment is more expensive.

School districts use their Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of health professionals and other specialized instructional support personnel (e.g., speech-language pathologists, audiologists, occupational therapists, school psychologists, school social workers, and school nurses) who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services available to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursements to purchase and update specialized equipment (e.g., walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and seeing) as well as assistive technology for students with disabilities to help them learn alongside their peers.

School districts would stand to lose much of their funding for Medicaid under the AHCA. Schools currently receive roughly \$4 billion in Medicaid reimbursements each year. Yet under this proposal, states would no longer have to consider schools as eligible Medicaid providers, which would mean that districts would have the same obligation to provide services for students with disabilities under IDEA, but no Medicaid dollars to provide medically-necessary services. Schools would be unable to provide EPSDT to students, which would mean screenings and treatment that take place in school settings would have to be

moved to physician offices or hospital emergency rooms, where some families may not visit regularly or where costs are much higher.

In addition, basic health screenings for vision, hearing, and mental health problems for students would no longer be possible, making these problems more difficult to address and expensive to treat. Moving health screenings out of schools also reduces access to early identification and treatment, which also leads to more costly treatment down the road. Efforts by schools to enroll eligible students in Medicaid, as required, would also decline.

The Consequences of Medicaid Per Capita Caps Will Potentially Be Devastating for Children

Significant reductions to Medicaid spending could have devastating effects on our nation's children, especially those with disabilities. Due to the underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and services they need to access a Free and Appropriate Public Education (FAPE) and Early Intervention services. Potential consequences of this critical loss of funds include:

- **Fewer health services:** Providing comprehensive physical and mental health services in schools improves accessibility for many children and youth, particularly in high-needs and hard-to-serve areas, such as rural and urban communities. In a 2017 survey of school district leaders, half of them indicated they recently took steps to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical health care for many children.
- **Cuts to general education:** Cuts in Medicaid funding would require districts to divert funds from other educational programs to provide the services as mandated under IDEA. These funding reductions could result in an elimination of program cuts of equivalent cost in "non-mandated" areas of regular education.
- **Higher taxes:** Many districts rely on Medicaid reimbursements to cover personnel costs for their special education programs. A loss in Medicaid dollars could lead to deficits in districts that require increases in property taxes or new levies to cover the costs of the special education programs.
- **Job loss:** Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. Sixty-eight percent of districts use Medicaid funding to pay for direct salaries for health professionals who provide services for students. Cuts to Medicaid funding would impact districts' ability to maintain employment for school nurses, physical and occupational therapists, speech-language pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and those with a variety of educational needs are able to learn.
- **Fewer critical supplies:** Districts use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, weighted vests, lifts, and student-specific items that are necessary for each child to access curriculum as closely as possible to their non-disabled peers. Replacing this

equipment would be difficult if not impossible without Medicaid reimbursements.

- Fewer mental health supports: Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.
- Noncompliance with IDEA: Given the failure to commit federal resources to fully fund IDEA, Medicaid reimbursements serve as a critical funding stream to help schools provide the specialized instructional supports that students with disabilities need to be educated alongside their peers.

We urge you to carefully consider the important benefits that Medicaid provides to our nation's most vulnerable children. Schools are often the hub of the community, and converting Medicaid's financing structure to per-capita caps threatens to significantly reduce access to comprehensive health and mental and behavioral health care for children with disabilities and those living in poverty. We look forward to working with you to avert the harmful and unnecessary impacts the AHCA would impose on Medicaid, which has proven to benefit children in a highly effective and cost-effective manner.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to the coalition co-chairs via email: John Hill (john.hill@medicaidforeducation.org), Sasha Pudelski (spudelski@aasa.org), and Kelly Vaillancourt Strobach (kvaillancourt@naspweb.org).

Sincerely,

AASA, The School Superintendents Association
 Accelify
 American Civil Liberties Union
 American Dance Therapy Association
 American Federation of Teachers
 American Foundation for the Blind
 American Occupational Therapy Association
 American Psychological Association
 Association of Assistive Technology Act Programs
 Association of Educational Service Agencies
 Association of School Business Officials International (ASBO)
 Association of University Centers on Disabilities
 Autistic Self Advocacy Network
 Center for American Progress
 Center for Public Representation
 Clearinghouse on Women's Issues
 Colorado School Medicaid Consortium
 Conference of Educational Administrators of Schools and Programs for the Deaf
 Council for Exceptional Children
 Council of Administrators of Special Education
 Council of Parent Attorneys and Advocates
 Disability Rights Education & Defense Fund

Division for Early Childhood of the Council for Exceptional Children (DEC)
Health and Education Alliance of Louisiana
Healthy Schools Campaign
Healthmaster Holdings LLC
Higher Education Consortium for Special Education
Judge David L. Bazelon Center for Mental Health Law
LEAnet, a national coalition of local education agencies
Learning Disabilities Association of America
Lutheran Services in America Disability Network
Michigan Association of Intermediate School Administrators
Michigan Association of School Administrators
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education (NASDSE)
National Association of State Head Injury Administrators
National Black Justice Coalition
National Black Justice Coalition
National Center for Learning Disabilities
National Association of Councils on Developmental Disabilities
National Disability Rights Network
National Down Syndrome Congress
National Education Association
National Health Law Program
National Respite Coalition
National Rural Education Advocacy Collaborative
National Rural Education Association
National School Boards Association
Paradigm Healthcare Services
School Social Work Association of America
School-Based Health Alliance
Share Our Strength
Society for Public Health Education
Teacher Education Division of the Council for Exceptional Children
The Arc of the United States
United Way Worldwide

[Questions submitted for the record and their responses follow:]

MAJORITY MEMBERS:

VIRGINIA FOXX, NORTH CAROLINA, *Chairwoman*
 JOE WALDON, SOUTH CAROLINA
 DUNCAN HUNTER, CALIFORNIA
 SHARVY F. ROSE, TENNESSEE
 GLENN "GT" THOMPSON, PENNSYLVANIA
 TIM WAINWRIGHT, INDIANA
 BRETT GUTHRIE, KENTUCKY
 TODD SCOTT, NEVADA
 LOU BARLETTA, PENNSYLVANIA
 LANCE KLOSSNER, INDIANA
 BRADLEY EYNE, ALABAMA
 DAVID BRAT, VIRGINIA
 GLENN GROTHMAN, WISCONSIN
 ELISE STAFFANK, NEW YORK
 BOB W. ALLLEN, GEORGIA
 JASON LEWIS, MINNESOTA
 FRANCIS ROONEY, ILLINOIS
 PAUL MITCHELL, MICHIGAN
 TOM CONNITT, JR., VIRGINIA
 LLOYD R. BRUCKER, PENNSYLVANIA
 A. BRIAN FERGUSON, FLORIDA
 ROY PETER, KANSAS
 KAREN HANDEL, GEORGIA



COMMITTEE ON EDUCATION
 AND THE WORKFORCE
 U.S. HOUSE OF REPRESENTATIVES
 2176 RAYBURN HOUSE OFFICE BUILDING
 WASHINGTON, DC 20515-6100

MINORITY MEMBERS:

ROBERT C. "BOBBY" SCOTT, VIRGINIA, *Ranking Member*
 STEVE LEE, CALIFORNIA
 DAVID E. BONIOR, ARIZONA
 JOE COURTNEY, CONNECTICUT
 MARCIA L. FUDGE, OHIO
 JARED POLIS, COLORADO
 GREGORY K. CARMICHAEL, ARIZONA
 NORTHERN MARIANA ISLANDS
 FREDERICK S. WILSON, FLORIDA
 SUZANNE BONAMICI, OREGON
 MARK TAKANO, CALIFORNIA
 ALMA S. ADAMS, NORTH CAROLINA
 MARK DESALUENO, CALIFORNIA
 DONALD HONORS, NEW JERSEY
 LISA BLUNT ROCHSTER, DELAWARE
 PAUL KISTHAKAMORTHE, ILLINOIS
 CAROL SHEA PORTER, NEW HAMPSHIRE
 ADRIANO ESPINOSA, NEW YORK

December 19, 2017

Leana S. Wen, M.D., MSc., FAAEM
 Commissioner of Health for the City of Baltimore
 Baltimore City Health Department
 1001 E. Fayette Street
 Baltimore, MD 21202

Dear Dr. Wen:

Thank you, again, for testifying before the Committee on Education and the Workforce at the hearing titled "Close to Home: How Opioids are Impacting Communities" on Wednesday, November 8, 2017.

As a follow-up to your testimony, please find enclosed additional questions submitted by a member of the Committee for inclusion in the final hearing record. Please provide your written responses to Education Legislative Assistant Jake Middlebrooks **no later than January 3, 2017**. His number is (202) 225-6558 should you have any questions about this request.

Sincerely,

Virginia Foxx

Virginia Foxx
 Chairwoman

Dr. Wen
December 19, 2017
Page 2

Rep. Marcia Fudge (D-OH)

1. Dr. Wen, the President declared the opioid epidemic a Public Health Emergency in October. What does that mean for you as the head of a local public health agency? Without funding to go with the declaration, does a federal declaration make any real impact?
2. In your testimony you mention Baltimore's diversion efforts such as Drug Treatment Courts. We have also had drug courts in Cleveland since 1998, with hundreds successfully completing the program and realizing thousands of dollars in savings per participant for treatment and diversion over that of incarceration. Could you speak more about the outcomes you have seen from these diversion programs? What impact does having treatment placement immediately available have on participation?
3. I have heard from several stakeholders that the Institution for Mental Disease (IMD) exclusion presents a barrier to treatment for Medicaid recipients. Can you discuss how this exclusion, affects your ability to get people who need the help, access to substance abuse treatment?

CITY OF BALTIMORE

CATHERINE E. PUGH, Mayor

**HEALTH DEPARTMENT**

Leana S. Wen, M.D., M.Sc., FAAEM

Commissioner of Health

1001 E. Fayette St.

Baltimore, MD 21202

health.commissioner@baltimorecity.gov

Tel: 410-396-4387

January 2, 2018

TO: Members of the Subcommittee on Early Childhood, Elementary, and Secondary Education and the Subcommittee on Higher Education and Workforce Development

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Answers for the record
Dr. Leana Wen
"Close to Home: How Opioids are Impacting Communities"
November 8, 2017

1. Dr. Wen, the President declared the opioid epidemic a Public Health Emergency in October. What does that mean for you as the head of a local public health agency? Without funding to go with the declaration, does a federal declaration make any real impact?

- a. While I commend the President for raising awareness about the opioid epidemic through his Public Health Emergency declaration, his announcement did not come with a commitment for additional federal funding that is so desperately needed to save lives. National state of emergency declarations come with commitments for funding—new funding, not funding that is diverted from other critical priorities. When hurricanes devastate communities, it's understood that billions of dollars are required to rebuild homes and repair infrastructure. The same understanding applies for stopping an epidemic. In Baltimore and across the country, we desperately need these resources. Studies show that only 1 in 10 people with addiction receive the treatment that they need—a statistic we would not find acceptable for any other disease.
- b. We look to the President and to Congress to announce a specific dollar amount for new funding, not repurposed dollars that take away from other key health priorities. Without such a commitment, the Declaration will not be effective on the frontlines of this epidemic.
- c. If funding were to be allocated, we urge that Congress allocate new funding directly to local jurisdictions hardest hit by the opioid epidemic. While states have traditionally received block grants from the federal government, local jurisdictions are closest to the ground in service delivery, and understand the needs of residents the best. We urge Congress to consider direct support for local jurisdictions, particularly those in areas of greatest need, by providing cities and counties with the autonomy to innovate and provide real-time care for our residents. Cities and counties have been fighting this epidemic for

years. We know what works, and local officials should not have to jump through additional hoops to obtain the resources we need. In Baltimore, we have saved 1,500 lives in just two years with very limited resources. Imagine how many tens of thousands of lives can be saved around the country, if only we had the willpower to do so in the form of a real state of emergency declaration.

2. In your testimony you mention Baltimore's diversion efforts such as Drug Treatment Courts. We have also had drug courts in Cleveland since 1998, with hundreds successfully completing the program and realizing thousands of dollars in savings per participant for treatment and diversion over that of incarceration. Could you speak more about the outcomes you have seen from these diversion programs? What impact does having treatment placement immediately available have on participation?

- a. Baltimore City has a Drug Treatment program that has produced many anecdotal positive outcomes, with graduates reentering the workforce and reclaiming their families and lives. There is currently no longitudinal data due to funding and personnel constraints. We are seeking additional funding to track outcomes and formally evaluate the program. This and many other behavioral health programs are extremely underfunded, a problem that exists around the country.
- b. Based on anecdotal observations, numerous participants are completing Drug Treatment Court and getting connected with a recovery residence when necessary. A number of these participants are obtaining employment once they enter into Phase III of the Drug Treatment Court program. Some individuals are hired by their treatment programs (e.g., as house managers of their residential program) after they have been in recovery for a certain period of time (usually one year). These individuals often express how important it is for them to "give back" to the treatment facilities that helped them.
- c. It is important to mention that Drug Treatment Court is entirely grant funded. Thus, the development of a system to track the outcomes of participants would have to be paid for through additional grant funding. At the moment, the program has a database that captures participants' demographics, education levels, employment statuses, referral services, and other relevant information when they enter Drug Treatment Court. However, that database does not capture outcomes or drug testing results from parole or probation. Anecdotally, we have observed that some Drug Treatment Court graduates enroll in vocational/job training programs. For those who were employed when they enrolled in Drug Treatment Court, Court staff work with individuals' employers to help them keep their jobs, but have had varying levels of success. Therefore, while eliminating the IMD exclusion is important (as noted in Question #3), additional, sustained funding is critical to ensuring that Drug Treatment Court programs can afford the necessary personnel and develop the systems needed to properly assess their outcomes.
- d. It is unclear whether having treatment placement immediately has an impact on Drug Treatment Court participation. Again, anecdotally speaking, the result is mixed: For some individuals, treatment placement matters tremendously, and they are eager for the opportunity to plea to Drug Treatment Court. Others may see Drug Treatment Court as a

way to avoid jail time, or they may not fully comprehend the commitment-level and various requirements involved with Drug Treatment Court. On the other hand, some individuals are aware of the commitments involved or believe they might receive probation, and consequently, may decide not to plea into Drug Treatment Court.

- e. If Drug Treatment Courts divert individuals from the criminal justice system to treatment, local governments need additional funds to ensure that the treatment programs they enter are available and of good quality. Thus, increased funding would not only help Drug Treatment Courts develop a system to track program outcomes, but would also ensure that the intended benefits of program participation are being achieved.

3. I have heard from several stakeholders that the Institution for Mental Disease (IMD) exclusion presents a barrier for Medicaid recipients. Can you discuss how this exclusion affects your ability to get people who need the help, access to substance abuse treatment?

- a. In addition to treating patients, we must also change the dialogue around the nature of substance use disorders while we work towards preventing addiction. This effort has multiple components, including educating doctors and the public, and providing prevention and early intervention services throughout the life course.
- b. The IMD exclusion is a needless constraint on the country's ability to offer treatment to individuals with opioid use disorder. Maryland is fortunate to have recently been partially exempted from this exclusion as part of its Medicaid waiver, and we can thus speak from experience about the importance of eliminating it. The exclusion means that public funding for substance use disorder treatment is not adequately sensitive to need.
- c. Since treatment facilities with more than 16 beds cannot be funded through Medicaid, states must instead use block grants, allocating each facility some portion of whatever funding is available. This typically means that a facility will contract with a state or local agency to make a specific number of beds available over the course of a set amount of time (say, a year). This requires predicting how many beds will be needed—but of course such a prediction is impossible. If a treatment facility finds that demand exceeds the capacity for which it has contracted, there is often no recourse; it cannot expand services in response to increased demand.
- d. Eliminating the IMD exclusion and allowing Medicaid to fund these treatment centers allows them to shift to a fee-for-service model, where services can to some extent expand and contract in response to demand. And eliminating the exclusion would not just mean that individual treatment centers no longer need to worry about hitting an artificial funding cap. The same would be true for states themselves. Since Medicaid is an entitlement program, Medicaid funding for the treatment of opioid use disorder can expand as needed over time; if states could leverage those dollars, they would not be held hostage to finite block grants (the sizes of which cannot help but be somewhat arbitrary).
- e. It is important to clarify the following: While directing Medicaid funding to treating opioid use disorder is important, there are essential services for which Medicaid does not

reimburse. For example, additional funding is needed to support our outreach workers – “credible messengers” in recovery themselves – who help people in our EDs with opioid use disorders get into treatment. We are unable to bill Medicaid for this critical service. Thus, eliminating the IMD exclusion is necessary, but more can and needs to be done, including changing the reimbursement structure and committing much more funding to stem the tide of the opioid epidemic.